

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11495

11480

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>70 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Lynchburg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynchburg</u> d. STREET ADDRESS <u>3800 Sheringham Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Andrew Abernathy Sr.</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1880</u>
9. AGE (In years last birthday) <u>81 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Polk Abernathy</u>		14. MOTHER'S MAIDEN NAME <u>Annie Lucy Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>(S) Robert A. Abernathy Jr., Richards, Va.</u>	
17. INFORMANT <u>(S) Robert A. Abernathy Jr., Richards, Va.</u>		Address <u>110 Tazewell Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, primary unknown</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from <u>July 27, 1961</u> to <u>October 5, 1961</u> , that (X) (we) last saw the deceased alive on <u>October 5, 1961</u> and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>William P. Urschel</u> M.D. 22b. DATE SIGNED <u>October 6, 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. URSCHER, LT MC USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u>		23b. DATE THEREOF <u>7 Oct 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pulaski Tennessee</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Abernathy</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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Robert A. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11495

Item 1 Film G297 10/13/61 iwk

11481

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS #2 Warmsey		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Milton Addison		4. DATE OF DEATH Oct. 5 1961		5. SEX Male	
6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5 /96	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Robert H. Addison		14. MOTHER'S MAIDEN NAME Amanda Bowie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Son Vincent Addison Same as above		17. INFORMANT Amanda Bowie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Diarrhea transients secondary to acute, ulceriform colitis (chronic)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE John B. Umhau		22b. DATE 10/6/61		22c. PHYSICIAN'S NAME (Type) JOHN B. UMHAU	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion.,	
23d. LOCATION (City, town or County) Mt. Zion, Md.		23e. REC'D BY REGISTRAR DATE OCT 10 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Harris	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. ADDRESS Rockville Md.		24b. SIGNATURE _____	

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VS. A15MB
SM 9/60

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10819 Hobson St</u>		d. STREET ADDRESS <u>110819 Hobson St</u>	
3. NAME OF DECEASED (Type or print) <u>James Albert</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON SILVERMAN (Dec)</u>		14. MOTHER'S MAIDEN NAME <u>CELIA GHESLOCK (Dec)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Russel Albert</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>10-4-61</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u> </u>		22a. REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>10/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHELOM Cem.</u>	
22d. LOCATION (City, town, or county) <u>CAP. HTS. MD.</u>		22e. REC'D BY REGISTRAR <u> </u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		22g. FUNERAL DIRECTOR <u>Charles J. Jurek</u>	
22h. ADDRESS <u>4217-9 Ave</u>		22i. DATE <u>OCT 6 '61</u>	

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
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11498

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2-Form 0300

11/15/61

11483

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Maryland</i> c. LENGTH OF STAY IN lb <i>46 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Rehab Sanatorium</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington Washington</i> d. STREET ADDRESS <i>3724 Davenport St., N.W.</i> <i>4831 Flanders Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Bertha</i> Middle <i>E.</i> Last <i>Alexander</i>		4. DATE OF DEATH Month <i>October</i> Day <i>31</i> Year <i>1961</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 24 - 1880</i>	9. AGE (In years lost birthday) <i>81</i> yrs.	10. IF UNDER 1 YEAR Months <i>8</i> Days <i>1</i> Hours <i>1</i> Min.	11. IF UNDER 24 HRS. Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Orville Comstock</i>			14. MOTHER'S MAIDEN NAME <i>Mary Frazier</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Paul Alexander-son</i> Address <i>4831 Flanders Ave. Kensington, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, acute</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Arteriosclerosis, generalised</i> DUE TO (c) <i>Hemiplegia, right, severe, with aphasia Aug 1961</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hours</i> <i>5 yrs +</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from _____ 19 <i>51</i> to <i>Oct 31</i> , 1961, that (I) was last saw the deceased alive on <i>Oct 24</i> , 1961, and that death occurred at <i>4:45</i> M, from the causes and on the date stated above.						
22a. SIGNATURE <i>Stewart Clapp</i>		22b. DATE <i>Oct 31 1961</i>		22c. PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>		
22d. ADDRESS <i>4740 Chevy Chase Dr. Chevy Chase Md.</i>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <i>Oct 31 1961</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/2/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		
23d. LOCATION (City, town, or county) <i>Suitland, Maryland</i>		23e. REC'D BY REGISTRAR <i>NOV 2 '61</i>		23f. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>						

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11499

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11484

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u>				d. STREET ADDRESS <u>4500 Conn. Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>M.</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Markell</u>				14. MOTHER'S MAIDEN NAME <u>Lelia Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-36-2064</u>		17. INFORMANT <u>MRS. JEAN ALLEN EID, SAME AS # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X METASTATIC CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA BREAST</u> DUE TO (c) <u>8 YEARS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>10/6</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10/4</u> , 19 <u>61</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. S. Detwiler</u>				22b. DATE SIGNED <u>10/6/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. S. DETWILER</u>	
22d. ADDRESS <u>1025 CONN. AVE. D.C.</u>		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>OCT. 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>SUITLAND, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki's Sons</u>				25a. REC'D BY REGISTRAR <u>1756 Pa Ave N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
				DATE <u>OCT 10 '61</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

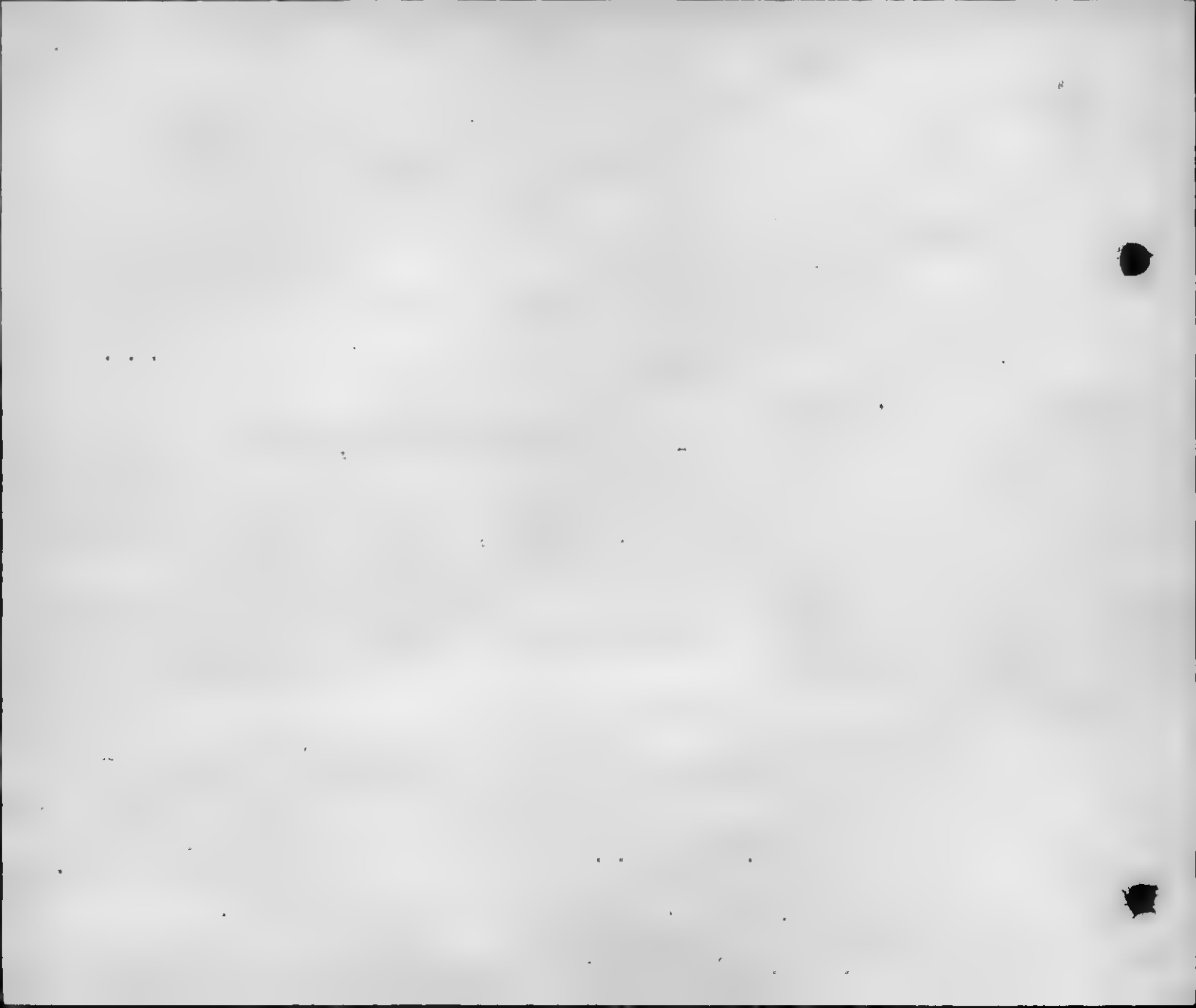
CERTIFICATE OF DEATH

11500

11485

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 38 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4309 Miami Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		3. NAME OF DECEASED (Type or print) Lawrence Joseph Anson		4. DATE OF DEATH October 8, 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1919		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence M. Anson		14. MOTHER'S MAIDEN NAME Mary Bartek		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 203-05-1460		17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarction, cerebellum, part of cerebrum and upper spinal cord DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH recent 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic packy and leptomeningitis																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (this hospital) attended the deceased from August 31, 1961, to October 8, 1961, that (we) last saw the deceased alive on October 8, 1961, and that death occurred at 12:05 PM from the causes and on the date stated above.																					
22a. SIGNATURE John E. Somers, M.D.		22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		22d. LOCATION (City, town or county) (State)		22e. DATE SIGNED 10/8/61		22f. SIGNATURE Arthur S. Frank		22g. DATE OCT 9 '61		22h. SIGNATURE Arthur S. Frank							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/61		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City, town or county) (State)		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. DATE OCT 9 '61		23h. SIGNATURE Arthur S. Frank							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

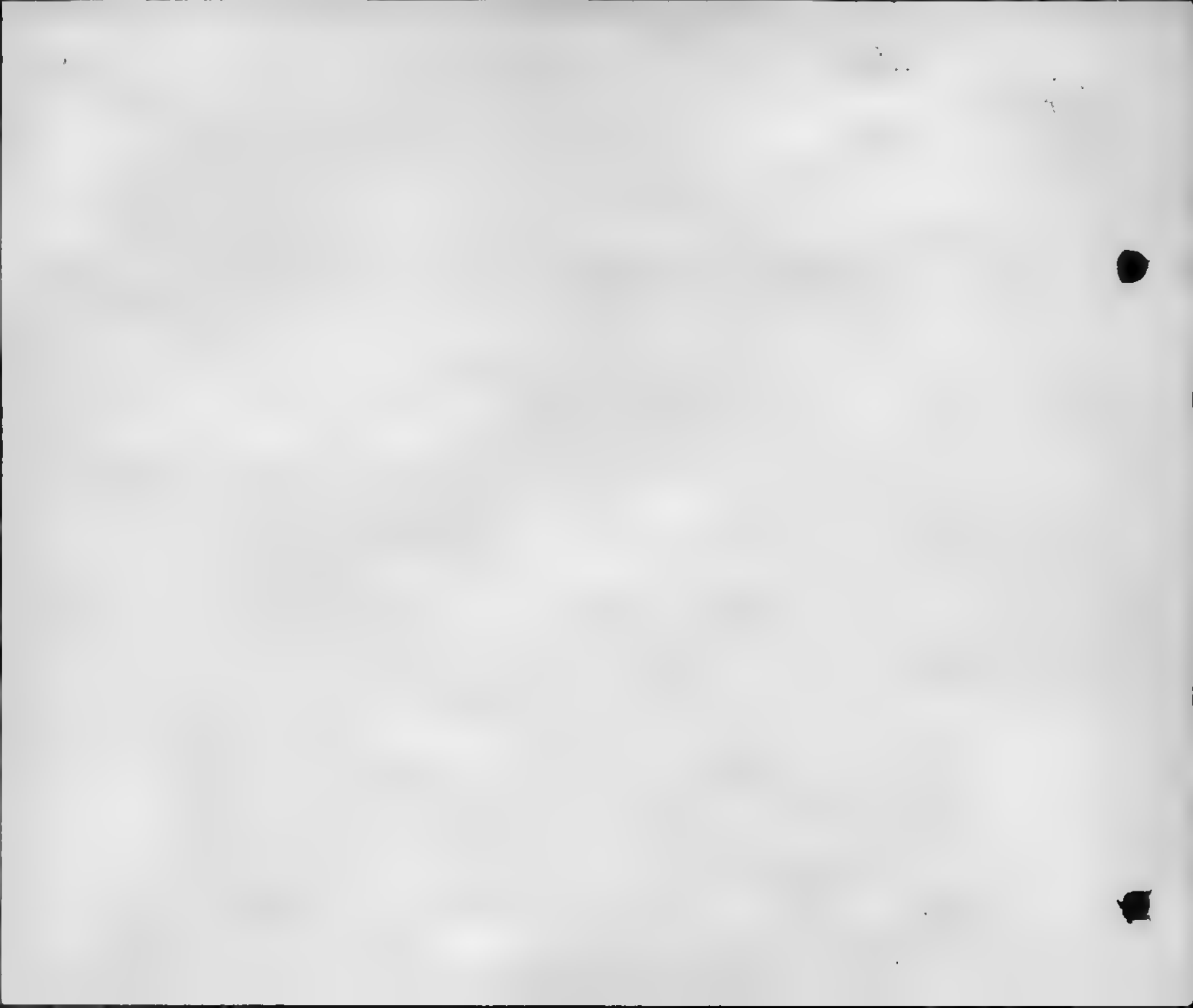
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11501

11486

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Col.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>20 Whittier St. N.W.</u> d. STREET ADDRESS <u>Argent</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u>		First <u>Henry</u> Middle <u>(NMN)</u> Last <u>Argent</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-02</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof reader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Henry Argent</u>		14. MOTHER'S MAIDEN NAME <u>Alice Twillan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-40-4629</u>			
17. INFORMANT <u>Keep Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 mos</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23, 1961</u> to <u>Oct 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 23, 1961</u> , and that death occurred <u>1222pm</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Raymond O. West</u>				22b. DATE SIGNED <u>10/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>			
22d. ADDRESS <u>TAKOMA PARK, MD</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		22g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 26, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) <u>Prince George's County, Md.</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24b. ADDRESS <u>254 Canal St. NW D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 25 '61</u>			
25b. REGISTRAR'S SIGNATURE <u> </u>				25c. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		25d. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

M

Any delay is necessary, funeral director, Page 1, 2, and 3 may be retained for your files. Page 5 must be retained for your files. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY in b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF DECEASED

(Type or print)

Rheba Glenn

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

6-6-1914

9. AGE (in years last birthday)

47 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

2. USUAL RESIDENCE

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

322 Scott Drive

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

4. DATE OF DEATH

Month

October

Day

4

Year

1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk-Stenographer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

J. Nelson Gates

14. MOTHER'S MAIDEN NAME

Bessie F. Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

Mr. Edward L. Ay - 322 Scott Drive, Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

434.4

DUE TO

ARTERIAL FIBRILLATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

PARTIAL OBSTRUCTION OF CARDIAC

(c)

CHRONIC MYOCARDIAL INFARCTION WITH EMBOLI

INTERVAL BETWEEN ONSET AND DEATH

HOURS

DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschant

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. Broschant

DEPUTY MEDICAL EXAMINER

10-5-61

22a. BURIAL, CREMATION REMOVAL (Specify)

Funeral

22b. DATE THEREOF

10-9-61

22c. NAME OF CEMETERY OR CREMATORY

Landon Park Cemetery

22d. LOCATION (City, town, or country)

Balto Maryland

(State)

23. FUNERAL DIRECTOR

Wm. J. Helmer-Sore

ADDRESS

Balto Md

24a. REC'D BY REGISTRAR

OCT 9 '61

24b. REGISTRAR'S SIGNATURE

Carlton S. Kraus



1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

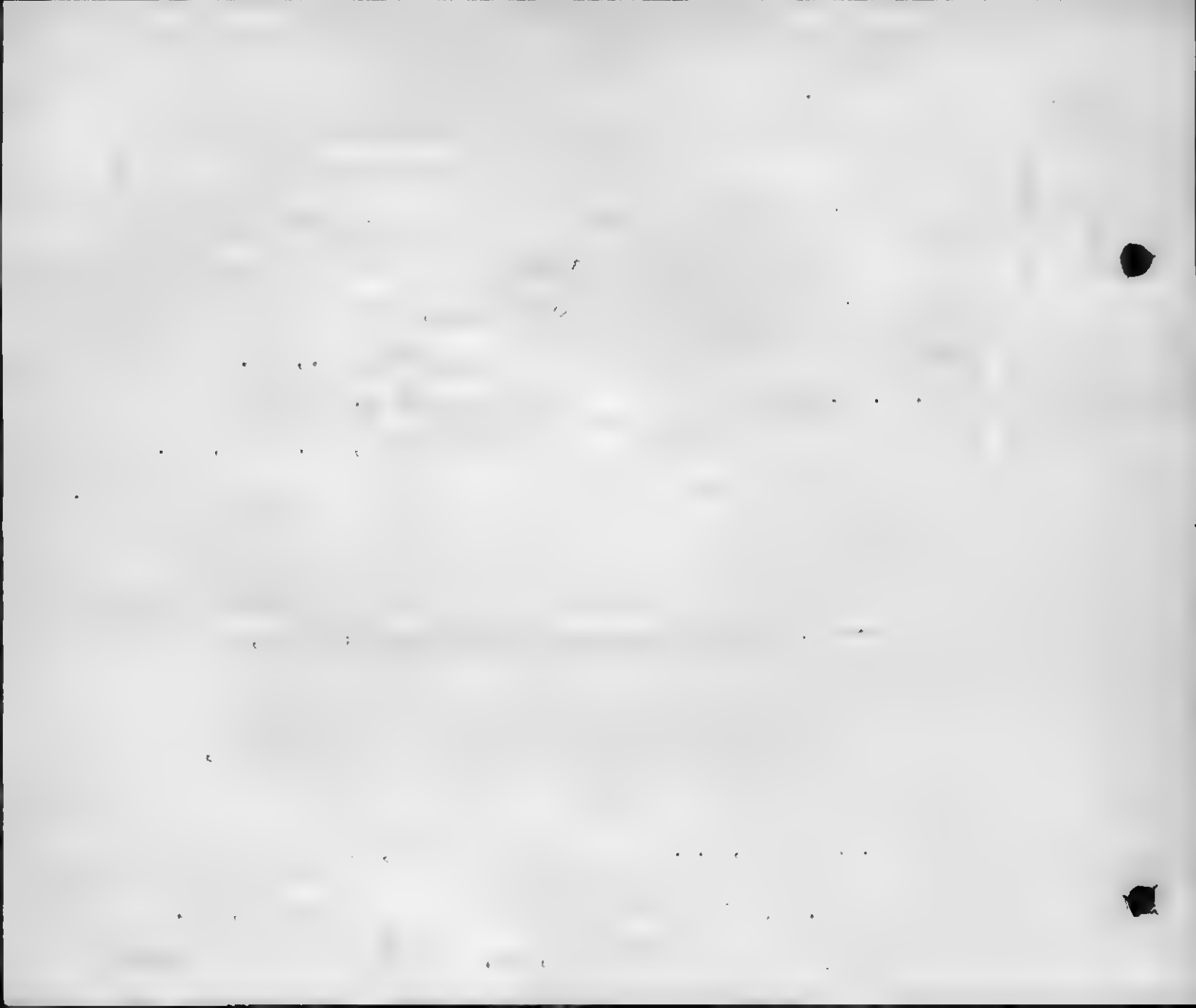
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11503

CERTIFICATE OF DEATH

11488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> <u>50 days</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Kempton</u> d. STREET ADDRESS <u>RFD # 1, Monrovia</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma Edith Baker</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 15, 1872</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.				4. DATE OF DEATH <u>October 9 1961</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>J. C. W. Kemp</u> 14. MOTHER'S MAIDEN NAME <u>Florence E. Adams</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs Edith Brown, Mt. Airy, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Sigmoid Colon</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized; congestive heart failure; anemia, secondary.</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 , to <u>October 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 8 1961</u> , and that death occurred <u>2:45M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. F. Meadors, M.D.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M.D.</u>				22d. ADDRESS <u>Damascus, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>		23d. LOCATION (City, town or county) <u>Kempton, Md.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Molesworth</u>				ADDRESS <u>Damascus, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 '61</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)

Bethesda, (Rural)

c. LENGTH OF STAY IN 1b

35 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U.S. Naval Hospital, Bethesda, Maryland

3. NAME OF DECEASED
(Type or print)

Harry

Hartwick

BAKER

2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)

a. STATE

b. COUNTY

D.C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

1735 L Street, N.W.

4. DATE OF DEATH

Oct. 29

1961

8. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-6-98

9. AGE (In years last birthday)

63 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Entertainer

10b. KIND OF BUSINESS OR INDUSTRY

Novelty Shop

11. BIRTHPLACE (County & State, or foreign country)

Illinois

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry L. HARTWICK

14. MOTHER'S MAIDEN NAME

Margaret Rush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

yes

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

(Brother)

Maurice HARTWICK 14239 Young Ave.

Detroit, Michigan

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that (a) (this hospital) attended the deceased from 9-25-1961, to 10-29-1961, that (b) (we) last saw the deceased alive on 10-29-1961, and that death occurred at 5:55 PM on the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

W. F. WARRENDER LT MC USN

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Maryland

22b. DATE SIGNED

10-30-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

11/2/61

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION (City, town or county)

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

1756 Pa. Ave., N.W.

25a. REC'D BY REGISTRAR

DATE NOV 1 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krawt

J.P. GAWLER FUNERAL HOME

Washington, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11505

11490

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>6 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>6821 Standish Drive</i>			
3. NAME OF DECEASED (Type or print) First <i>Didie</i> Middle <i>A.</i> Last <i>Bauer</i>				4. DATE OF DEATH Month <i>OCTOBER</i> Day <i>28</i> Year <i>19 61</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-6-16</i>	
9. AGE (In years last birthday) <i>45</i> yrs.		10. IF UNDER 1 YEAR Months <i>45</i> Days <i>45</i> Hours <i>45</i> Min		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printing Office Ass't. Unit Supv.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>North Carolina</i>			
13. FATHER'S NAME <i>Marcus D. Alfred</i>				14. MOTHER'S MAIDEN NAME <i>Fannie V. Ray</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-----</i>		17. INFORMANT <i>Edward J. Bauer</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Coma</i> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hepatic metastases</i> DUE TO (c) <i>Carcinoma of the Pancreas.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 mos.</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus 2° to # 18(c)</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/23/61</i> 19 <i>61</i> to <i>10/28/61</i> 19 <i>61</i> that (I) (we) last saw the deceased alive on <i>10/23/61</i> 19 <i>61</i> and that death occurred on <i>10/28/61</i> am the causes and on the date stated above							
22a. SIGNATURE <i>Henry C. Scruggs</i>				22b. ADDRESS <i>7720 Wisconsin Ave Bethesda Md</i>		22c. PHYSICIAN'S NAME (Type) <i>HENRY C. SCRUGGS</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>NOV. 1, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL'S METHODIST CHURCH CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>HAMPTONVILLE, N. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>				25a. REC'D BY REGISTRAR <i>DATE OCT 31 '61</i>		25b. REGISTRAR'S SIGNATURE <i>William L. Evans</i>	
WARNER E. PUMPHREY, INC., SILVER SPRING, MD.							

(M)

074

(I)

MEDICAL CERTIFICATION

1

10/28/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

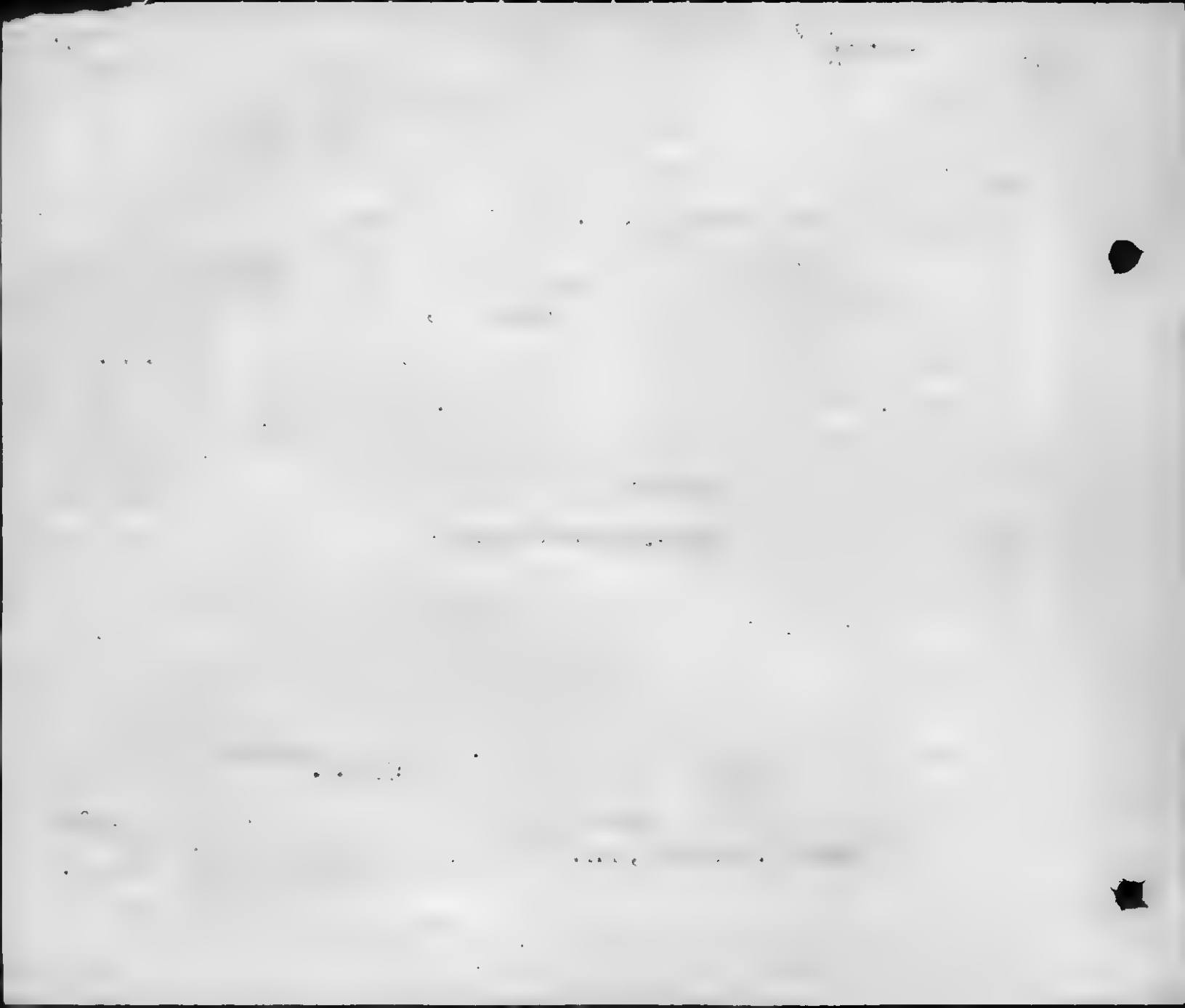
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11506

11491

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Elizabeth City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 Bell Street</u> d. STREET ADDRESS <u>October 3, 1961</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bryan Keith Baum</u> f. SEX <u>Male</u> g. COLOR OR RACE <u>White</u> h. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> i. FATHER'S NAME <u>Hezekiah D. Baum</u>		j. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> k. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> l. DATE OF BIRTH <u>January 20, 1956</u> m. AGE (In years, last birthday) <u>5 yrs.</u> n. DATE OF DEATH <u>October 3, 1961</u> o. IF UNDER 1 YEAR, IF UNDER 24 HRS. p. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> (b) <u>Acute Myelogenous Leukemia</u> (c) <u>Terminal Colitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>11 Months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Terminal Colitis</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>None</u>	
20g. (County) <u>None</u>		20h. (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 22, 1961</u> to <u>October 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 3, 1961</u> , and that death occurred at <u>6:35 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Henderson, M.D.</u>		22b. DATE SIGNED <u>10/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. HENDERSON, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>None</u>		23d. LOCATION (City, town or county) <u>Elizabeth City, N.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>1110 Chapin St. N.W. Wash. D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507

Items received from 11/1/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

11492

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Acensington</u> X			
c. LENGTH OF STAY IN TB <u>10 yr 9m</u>				d. STREET ADDRESS <u>25 Cleveland Ave. 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooks Grove Foundation Inc</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minerva Emily Baum</u>				4. DATE OF DEATH Month Day Year <u>Oct. 22 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1876 June 23, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walter Graves</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Anne Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>John C. Baum 4017 Cleveland St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal ca - Rt breast</u> DUE TO <u>Rem. Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 18 1954</u> to <u>Oct 22 1961</u> , that I last saw the deceased alive on <u>Oct 13 1961</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Boskey Ziegler M.D.</u>				ADDRESS (Street, city or town, state) <u>OLNEY, MD</u> DATE SIGNED <u>10/22/61</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>				Olney, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 25 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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132

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11508

11493

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8101 Old Georgetown Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8101 Old Georgetown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STELLA 4. DATE OF DEATH October 29 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/11/1891 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 70 yrs. 8 Months 18 Days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Haney		14. MOTHER'S MAIDEN NAME Eva K. Morrison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Everett Bean-Husband-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL PULMONARY EMBOLISM DUE TO (b) ATHEROSCLEROTIC HEART DISEASE DUE TO (c) SURGERY - MESENTERIC THROMBOSIS - AUG 1961 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) June 1960 to OCT 1961, that (I) (we) last saw the deceased alive on OCT 27 1961, and that death occurred at 5A.M. from the causes and on the date stated above.		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to OCT 1961 , that (I) (we) last saw the deceased alive on OCT 27 1961 , and that death occurred at 5A.M. from the causes and on the date stated above.		22a. SIGNATURE Leo I. Donovan M.D. 22c. PHYSICIAN'S NAME (Type) LEO I DONOVAN M.D.		22b. DATE SIGNED 10/30/61 22d. ADDRESS 8316 WISE AVE BETHESDA 14 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/61		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		23d. LOCATION (City, town or county) (State) Rockville, Maryland		25a. REC'D BY REGISTRAR NOV 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna					

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

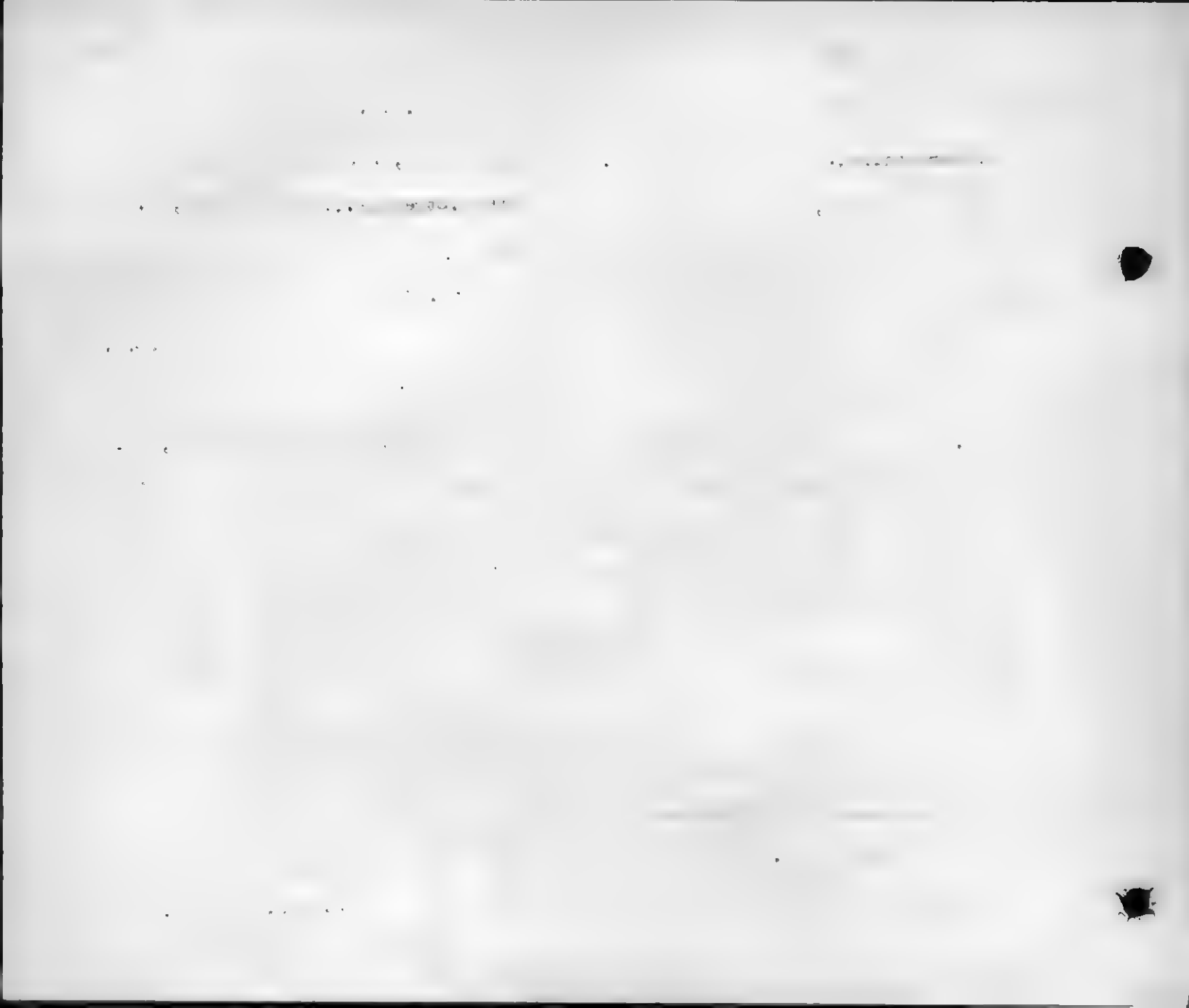
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11509

11494

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland		c. LENGTH OF STAY IN 1b 5 years.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 215 A. Street, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8702 Geron Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ora Middle Gerhart Last Beatty		4. DATE OF DEATH Month 10 Day 6 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8th, 1872
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Gerhart		14. MOTHER'S MAIDEN NAME Sarah Dally	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO 578 20 980	
17. INFORMANT Daughter		Address Iris Beatty Johnson 3829 S Street, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive - arteriosclerotic DUE TO (c) Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 61 to Oct 61, that (I) (we) last saw the deceased alive on 10-3 19 61, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald		22d. ADDRESS 217 Univ. Bldg E. S.S., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/7/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Birchinson		25a. REC'D BY REGISTRAR DATE OCT 1 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

WASH D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

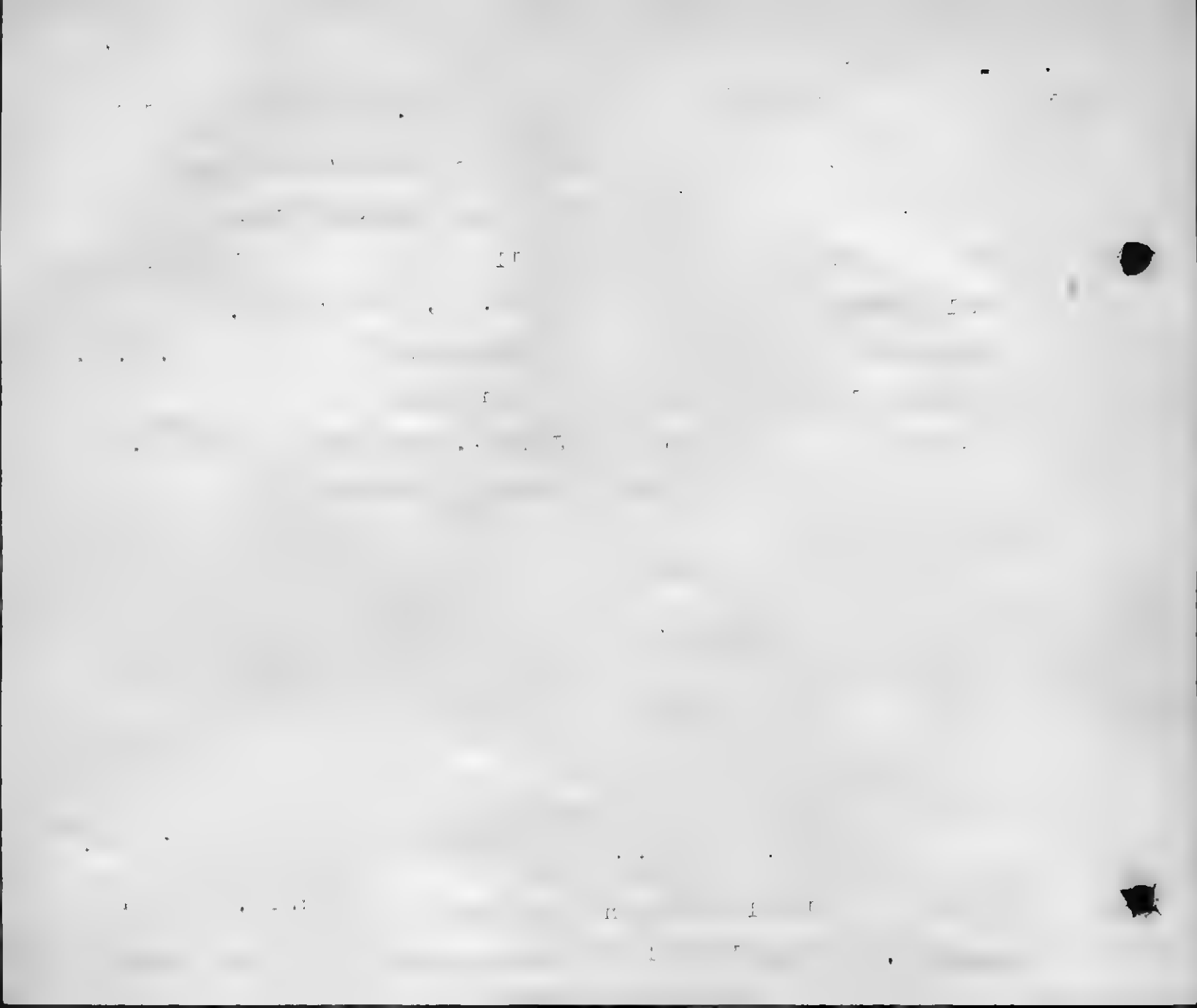
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11510

CERTIFICATE OF DEATH

11495

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON - MD c. LENGTH OF STAY IN 1b 10-14-61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WHEATON NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Halethorpe) d. STREET ADDRESS 1820 Woodside Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fanny 4. DATE OF DEATH October 16, 1961		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 15, 1882 9. AGE (In years last birthday) 79 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rufus Tyler 14. MOTHER'S MAIDEN NAME Annie LeBrun		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT James A. Bell 1809 Arbutus Ave. #27 Address (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary artery disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) Metastatic tumor of the liver - ascites PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholelithiasis Arthritis		INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 5-29-1961 to 10-16-1961 , that <input type="checkbox"/> (we) last saw the deceased alive on 10-16-1961 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles R. Shultz, M.D. 22b. DATE SIGNED 10-16-61		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Charles R. Shultz, M.D.		22d. ADDRESS 9 Dewey Drive Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/19/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR Arthur S. Kline 25b. REGISTRAR'S SIGNATURE Arthur S. Kline DATE OCT 18 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11511

CERTIFICATE OF DEATH

11496

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

OLNEY

c. LENGTH OF STAY IN 1b

3 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MONTGOMERY GENERAL

3. NAME OF DECEASED

First

WILLIAM

Middle

Last

BELL

4. DATE OF DEATH

Month

OCT.

Day

11

Year

19 61

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. MARRIED

NEVER MARRIED

WIDOWED

D VORCED

8. DATE OF BIRTH

12-10-77

9. AGE (In years last birthday)

83

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED (NOT KNOWN)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

MARYLAND

13. FATHER'S NAME

WILLIAM DAYTON BELL

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

HOSPITAL RECORDS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Bilateral bronchopneumonia

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

10 years

3 days

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10/8/61 to 10/11/61, that (I) (we) last saw the deceased alive on 10/10/61, and that death occurred at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE

James P. Kerr

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

JAMES P. KERR, M.D., DAMASCUS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 10-14-61

23c. NAME OF CEMETERY OR CREMATORY

Brooke Grove

23d. LOCATION (City, town or county)

Laytonsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Robert L. Andrews

ADDRESS

Rockville, Md.

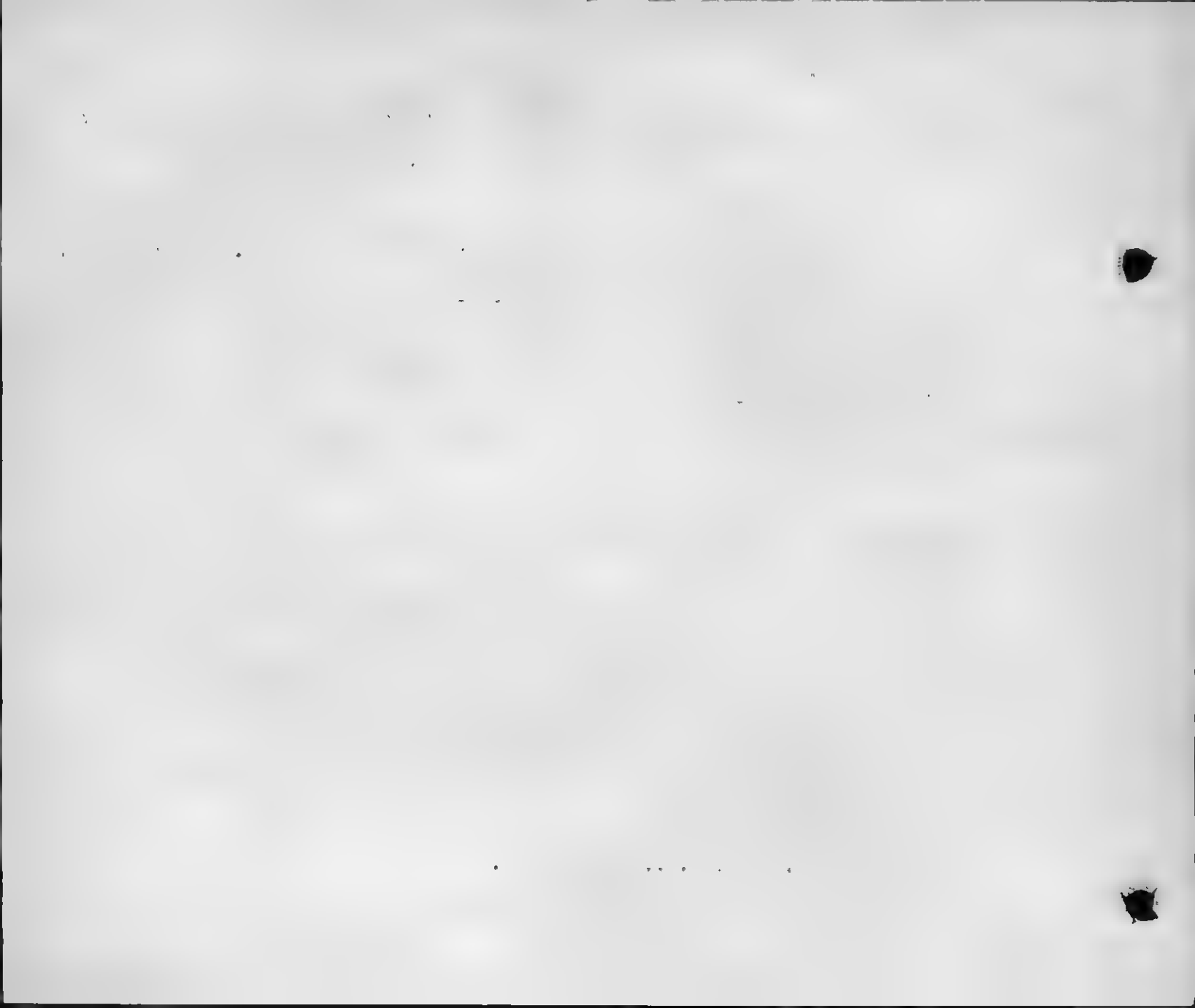
25a. REC'D BY REGISTRAR

DATE OCT 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

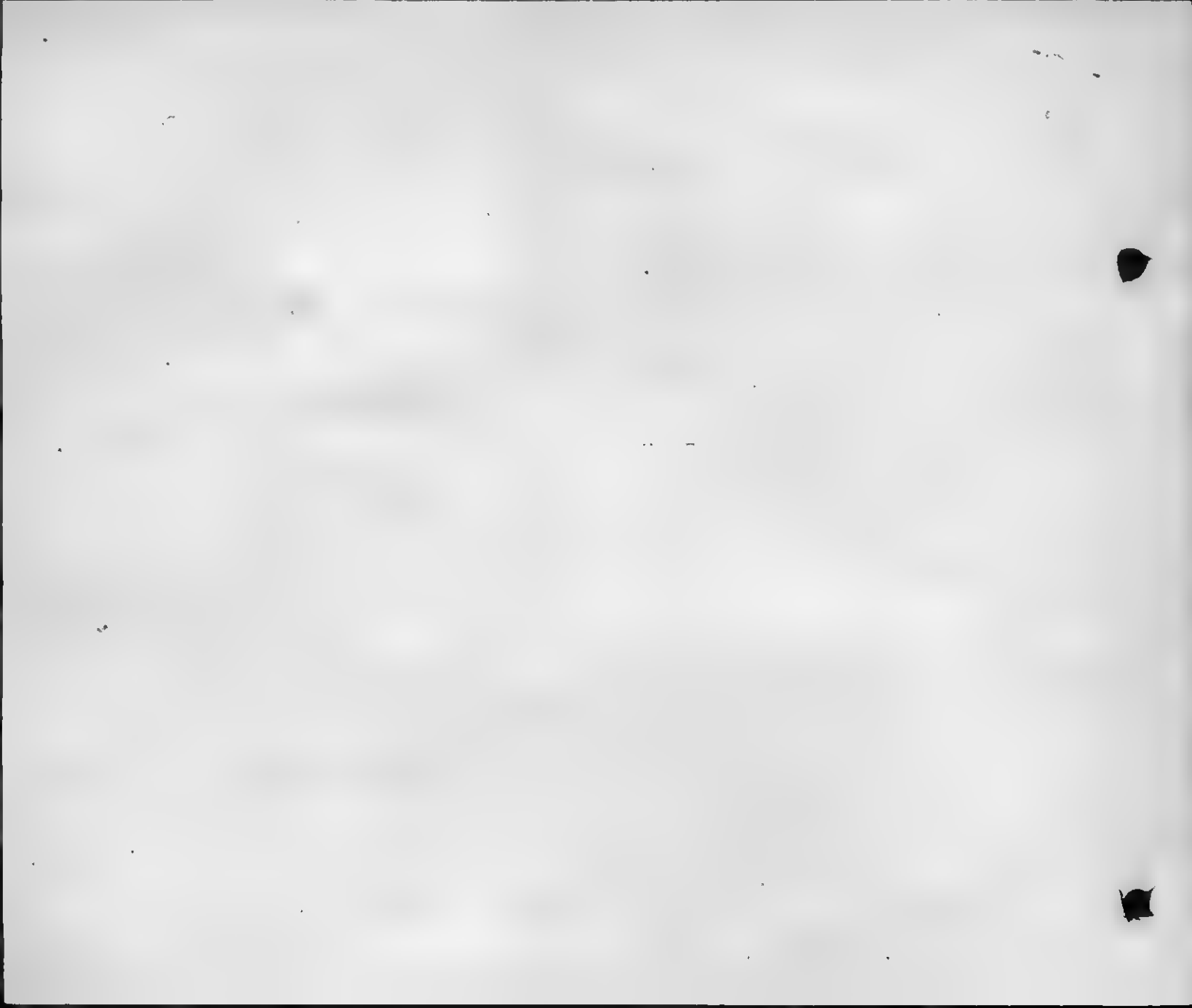
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11512

CERTIFICATE OF DEATH

11497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY (If in hospital, give street address) <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>402 Silver Rock Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie (Cappie) Benson</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/4/97</u> 9. AGE (in years last birthday) <u>64</u> rs. <u>6</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 11. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Collins</u> 14. MOTHER'S MAIDEN NAME <u>(Unknown)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>215-26-3740D</u> 17. INFORMANT <u>Son Arthur Benson</u> Same as above <u>Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>coronary thrombosis</u> DUE TO (c) <u>coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis and asthma</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. CITY OR TOWN (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1951</u> to <u>10/4/1961</u> , that (I) (we) last saw the deceased alive on <u>10/4/1961</u> , and that death occurred <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u> 22d. ADDRESS <u>809 Viers Mill Rd. Rockville, Md.</u>		22b. DATE SIGNED <u>10/4/61</u> 22e. REC'D BY REGISTRAR <u>Oct 6 '61</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
23a. BURIAL, CREMATORY, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Potomac, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Oct 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn & Hosp</u>		d. STREET ADDRESS <u>1712 Hudson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Randy</u>		DATE OF DEATH <u>10-31-61</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Bestpitch</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Cody</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Same as above</u>	
17. INFORMANT <u>George Bestpitch</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinosis of liver, congenital</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>		24. REC'D BY REGISTRAR <u>Arthur Walters</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>		DATE <u>NOV 3 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11514

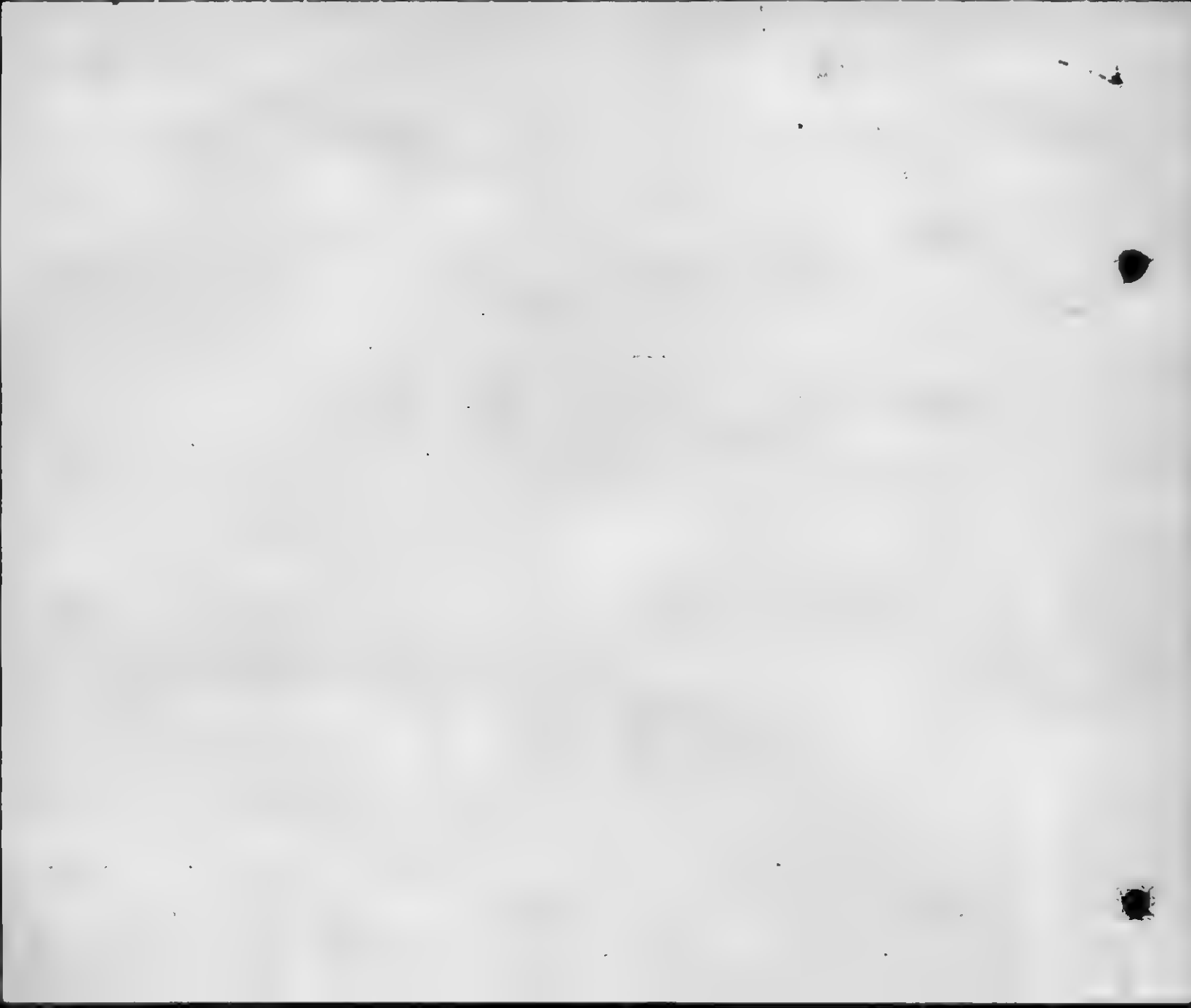
11499

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 11514 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5421 York Lane		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5421 York Lane	
3. NAME OF DECEASED (Type or print) Ida Belle BOGGS 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 29, 1872 9. AGE (In years last birthday) 89 yrs. 10. MONTHS 8 11. DAYS 9 12. IF UNDER 1 YEAR, IF UNDER 24 HRS. 19 61		4. DATE OF DEATH Oct. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
13. FATHER'S NAME Sanders Puray		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Marion W. Boggs-Son-Same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - 5271 DUE TO (b) Cardiovascular disease - Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c) Pulmonary Embolism -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Colon -			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , 19... to 8 Oct , 19 61 , that (I) (we) last saw the deceased alive on 29 Sept , 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED 9 Oct 1961	
22c. PHYSICIAN'S NAME (Type) John G. Ball		22d. ADDRESS 7936 Old Georgetown Rd. Beth. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur, Trans		23b. DATE THEREOF 10/10/61	
23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery		23d. LOCATION (City, town or county) (State) Columbia, Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REG. STRAR OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

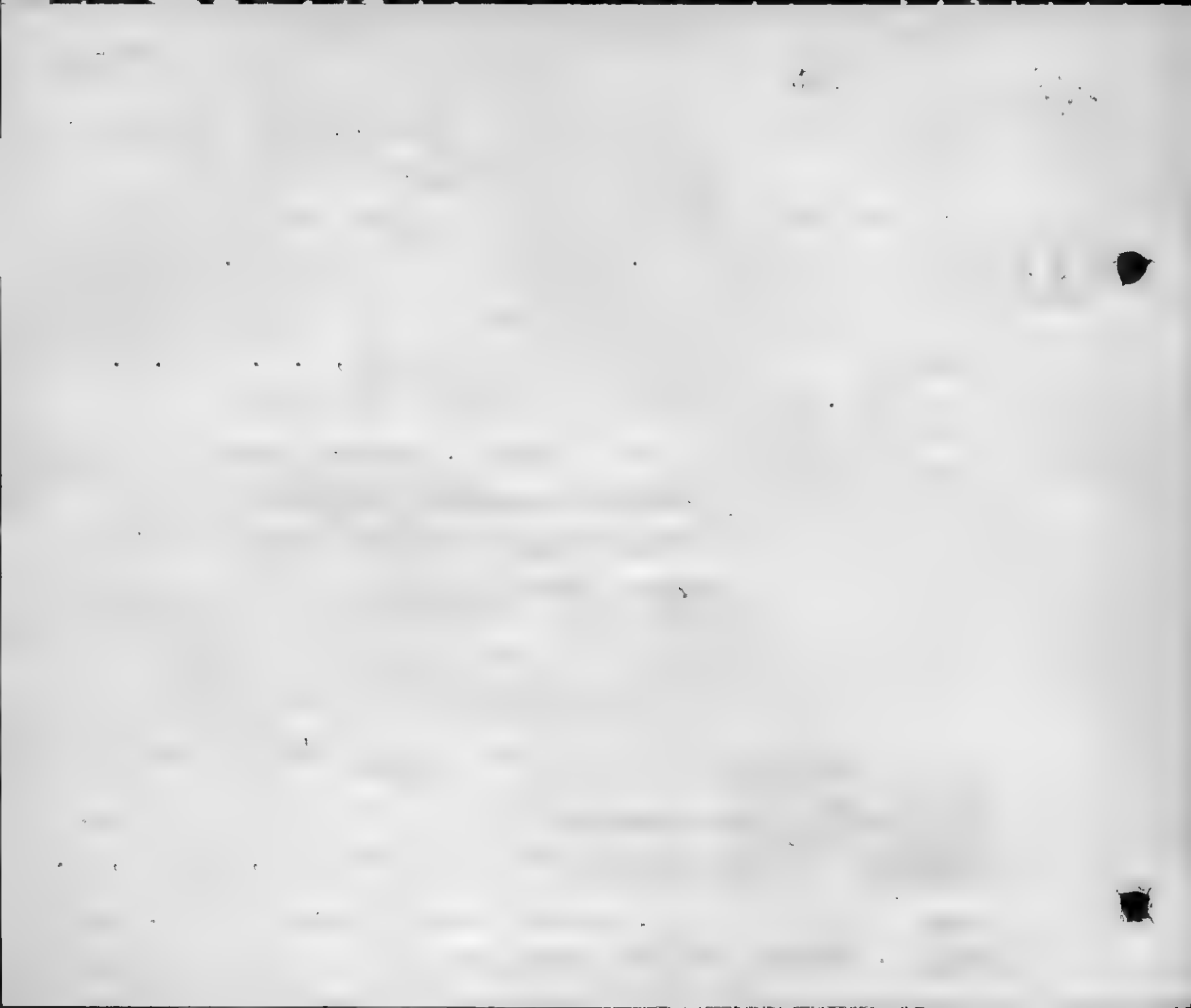
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11515

11500

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8614 Lancaster Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8614 Lancaster Drive	
3. NAME OF DECEASED (Type or print) MARGARET L. BRAGAW		4. DATE DEATH Oct. 15 19 61	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 27, 1888	
9. AGED (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR 3 Months 18 Days	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William J. Butler		14. MOTHER'S MAIDEN NAME Louise Ellen Andrews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None 17. INFORMANT George D. Bragaw-Son-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO (b) arteriosclerotic heart disease DUE TO (c) myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 25 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH immed.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
21. I certify that (I) (th's hospital) attended the deceased from May 17, 1961 , to Oct 11, 1961 , that (I) (we) last saw the deceased alive on Oct 11, 1961 and that death occurred at 10 AM , from the causes and on the date stated above.		22. SIGNATURE Wilfred R. Ehrmantraut M.D. 22b. DATE SIGNED 10/16/61	
23a. BURNAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince George Co. Maryland		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25. REC'D BY REGISTRAR OCT 19 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

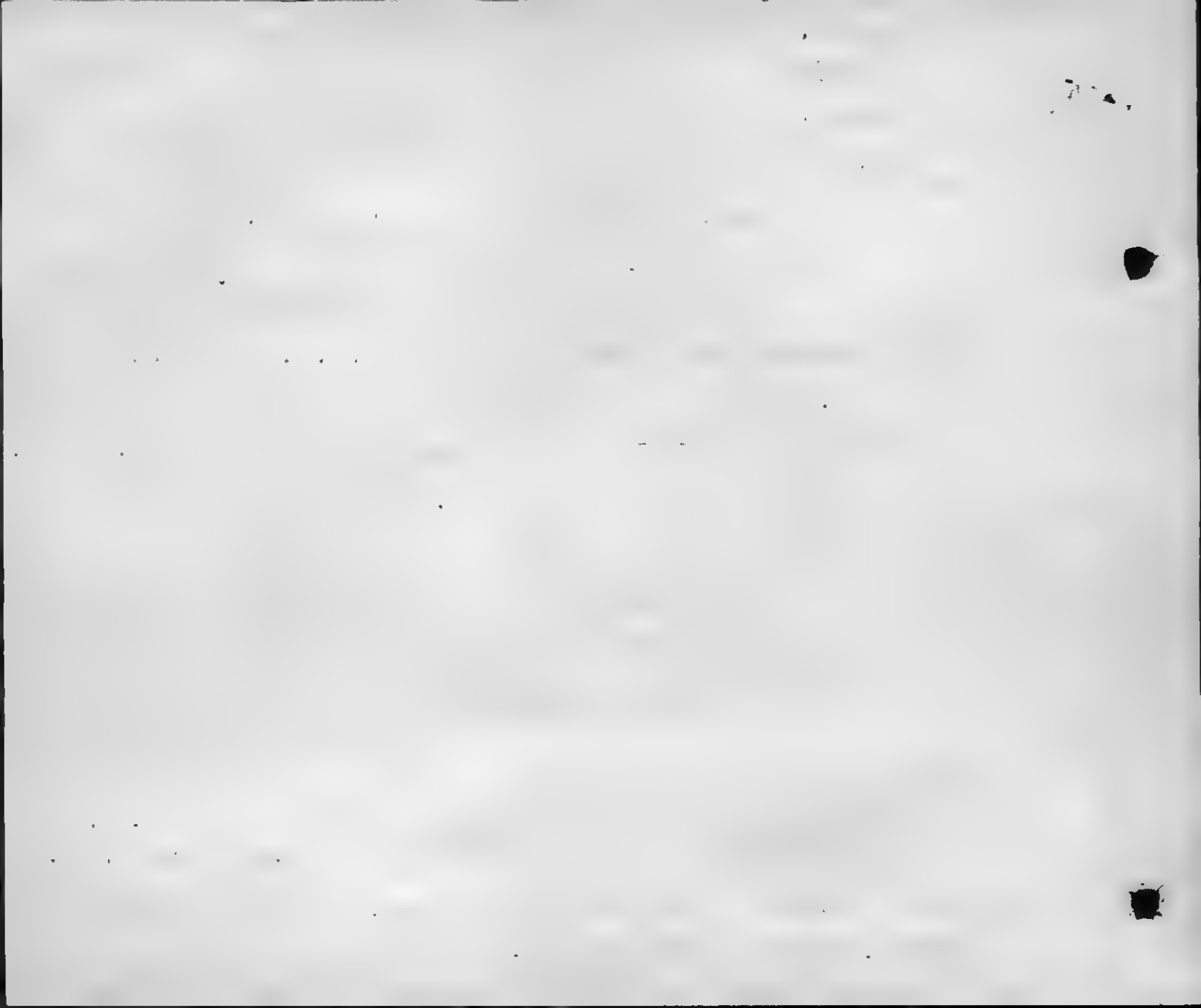


THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11516											
11501											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> c. LENGTH OF STAY IN 1b <u>4700 Bradley Blvd.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4700 Bradley Blvd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>4700 Bradley Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Dudley S. Bright</u>				4. DATE OF DEATH <u>October 5, 1961</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>1/19/84</u>				9. AGE (In years last birthday) <u>77</u> yrs. <u>8</u> months <u>16</u> days <u>16</u> hours <u>16</u> min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer-Ret. Civil Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert W. Bright</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Hutchinson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>084-07-7358</u> 17. INFORMANT <u>Albert Bright, son</u> Address <u>4809 Broadbrook Dr. Beth, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u> 177X DUE TO (b) <u>Sarcinomatosis</u> Conditions, if any, which gave rise to immediate cause (c) <u>Primary leiomyosarcoma, prostate</u> 177X DUE TO (c) <u>Primary leiomyosarcoma, prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of the prostate</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)			
20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>1959 to Oct 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 4, 1961</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George Sharpe</u> 22c. PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE</u>				22b. DATE SIGNED <u>Oct. 6, 1961</u> 22d. ADDRESS <u>10511 Sumit Ave., Kensington, Md.</u>				22e. REC'D BY REGISTRAR <u>Oct 13 '61</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-9-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Virginia</u>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				24b. ADDRESS <u>Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>Oct 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			





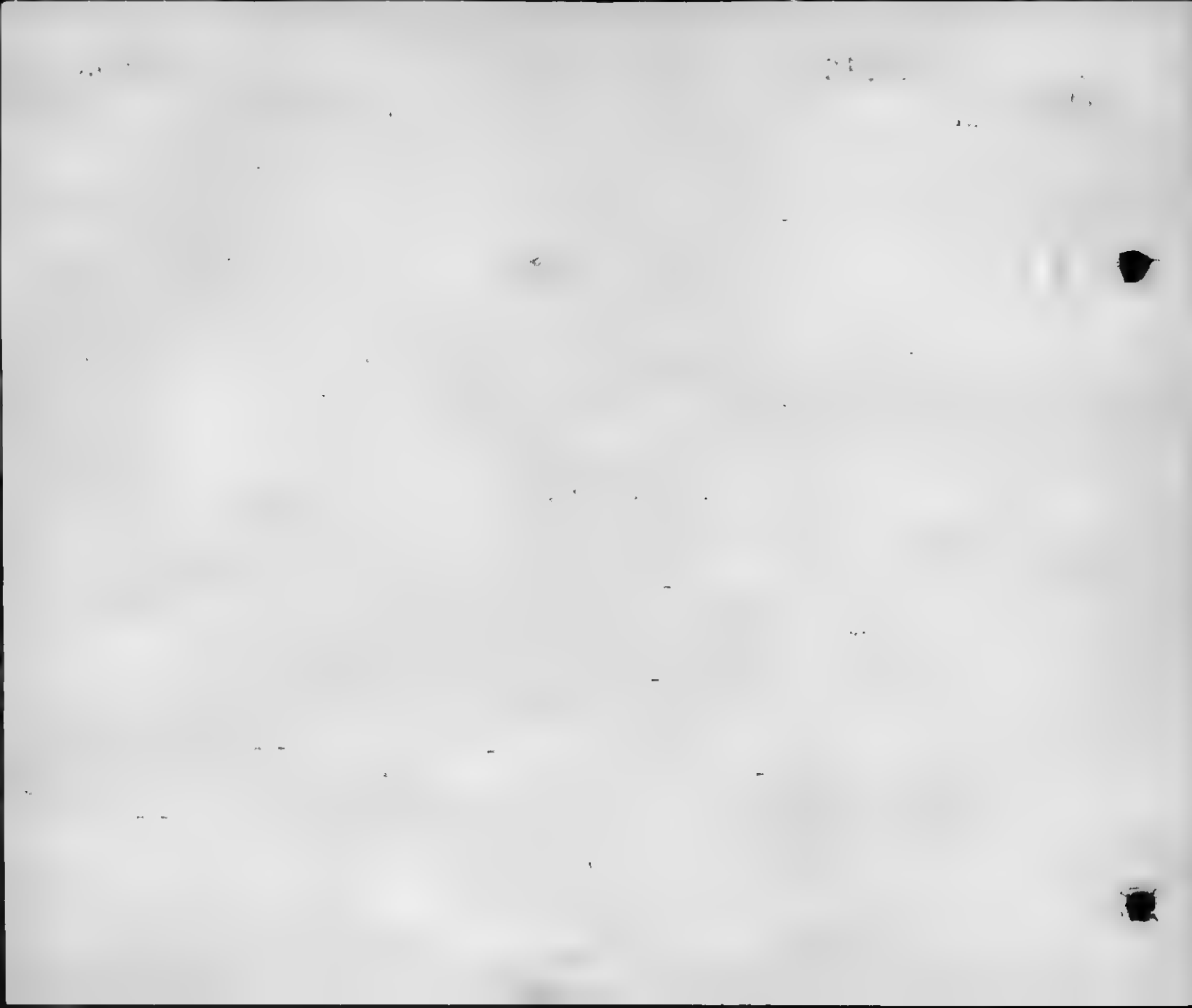
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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11518
11503
STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b. 47hrs 18min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD (MOTHER) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY (JONESTOWN) d. STREET ADDRESS 1322 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy "B" BROOKS		4. DATE OF DEATH Month 10 - Day 3 - Year 1961	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-61 6:47PM
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn		11. BIRTHPLACE (County & State or foreign country) Montgomery, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Chambers	
14. MOTHER'S M.A.DEN NAME Mary Dell Brookes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 763.5		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO (b) ATELECTASIS, CONGENITAL DUE TO (c) PREMATURITY		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-1-61 to 10-3-61 , 19 61 , that (I) (we) last saw the deceased alive on 10-3 , 19 61 , and that death occurred at 6:45PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, B.D.		22b. DATE SIGNED 10-4-61	
22c. PHYSICIAN'S NAME (Type) Dr. Charles Whitaker, M.D.		22d. ADDRESS Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-61	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Park		23d. LOCATION (City, town or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		25a. REC'D BY REGISTRAR DATE OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Whitaker			

3183x



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11519

Item 8-1111-6-97-10/16/61 ink

11504

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>11 Montgomery Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Thomas</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>12</u> - Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>11</u> - Day <u>18</u> - Year <u>1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>	
11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>6</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
17. INFORMATION <u>Hosp. Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>31X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>31X</u> DUE TO	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>	
21. MEDICAL CERTIFICATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		22. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 22a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 22b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>July 1956</u> 22c. (City or town) <u>Oct 12</u> (County) <u>1961</u> (State) <u>1961</u>	
23. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>Oct 12</u> , 1961, that (I) (we) last saw the deceased alive on <u>Oct 12</u> , 1961, and that death occurred at <u>3:18 PM</u> , from the causes and on the date stated above.		24. SIGNATURE 24a. PHYSICIAN'S NAME (Type) <u>James M. Whitlock M.D.</u> 24b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 24c. ADDRESS <u>7717 Carroll Ave Takoma Park Md</u>	
25. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		26. DATE THEREOF <u>Oct. 16, 1961</u>	
27. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		28. LOCATION (City, town or county) <u>Washington, D.C.</u>	
29. REC'D BY REGISTRAR <u>Arthur L. Walters</u>		30. REGISTRAR'S SIGNATURE <u>Arthur L. Walters</u>	
31. DATE <u>OCT 16 '61</u>		32. ADDRESS <u>254 Carroll St. W. Wash, D.C.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

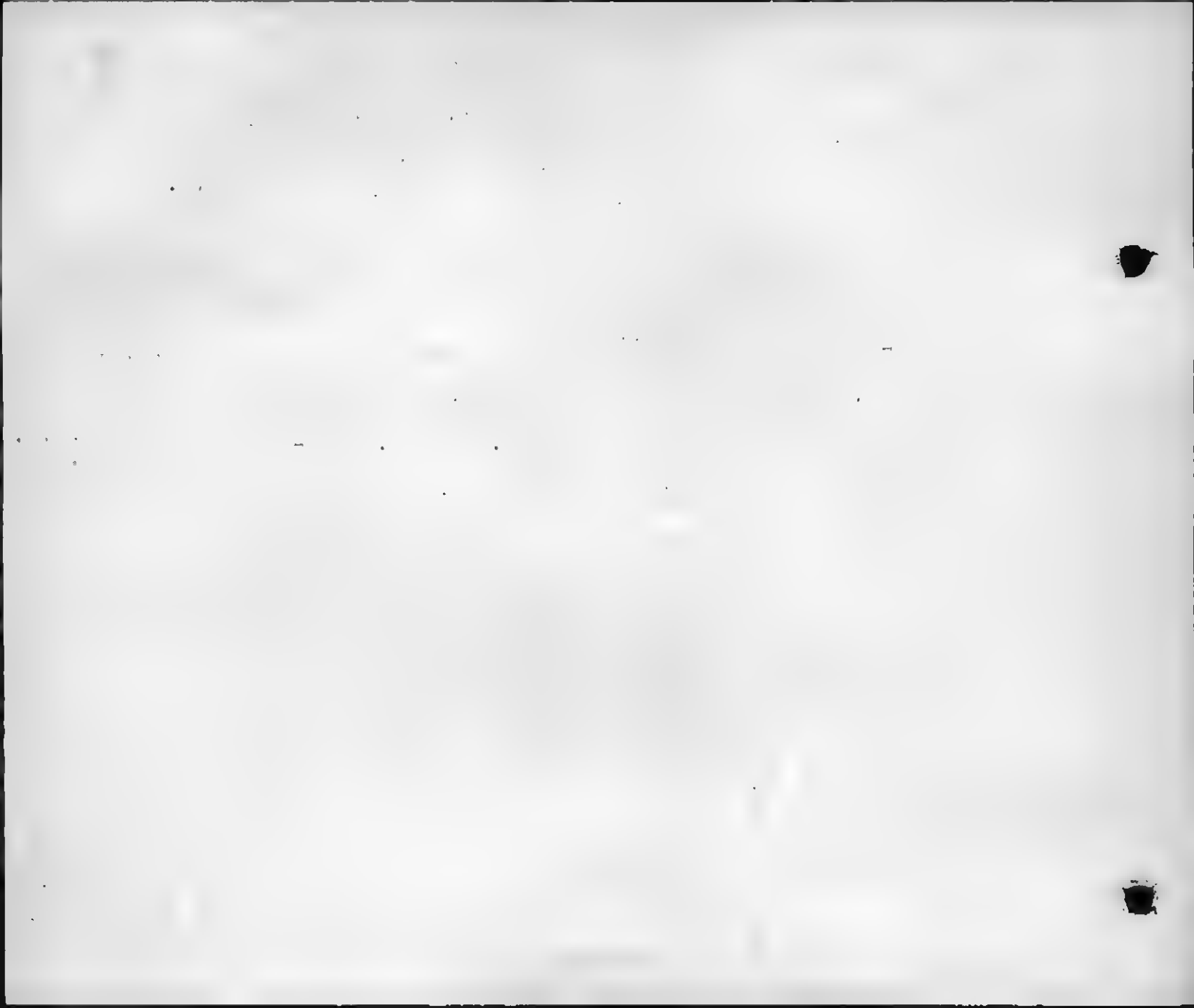
11505

11520

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Dist. of Columbia b. COUNTY Columbia ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 42x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 2901 Connecticut Ave. N.W.			
3. NAME OF DECEASED (Type or print) First Frank Middle I Last BROWN				4. DATE OF DEATH Month 10 Day 22 Year 1961			
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-3-86		9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Attorney for Federal Trade Commission				10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irving A. Brown				14. MOTHER'S MAIDEN NAME Mary Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Address Mrs. Ella A. Brown - 2901 Conn. Ave., N.W. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 days (c) 20 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2 to 10/22 , 19 61 , that (I) (was) lost saw the deceased alive on 10/22 19 61 and that death occurred on 10/22 M. from the causes and on the date stated above							
22a. SIGNATURE John E. Everett				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT	
22d. ADDRESS 9400 CONN. AVE. Kensington Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John S. H. Hines Co.				25a. REC'D BY REGISTRAR 2901-1748 N.W.		25b. REGISTRAR'S SIGNATURE DATE OCT 24 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11521

11506

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5105 North Capitol Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman W. Brown 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH March 24, 1919 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 42 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-- Construction Work 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Wilfred W. Brown 14. MOTHER'S MAIDEN NAME Iva I. Rogers 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) 16. SOCIAL SECURITY NO no 17. INFORMANT Laura S. Brown-- Same #2 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure DUE TO (b) old coronary occlusion DUE TO (c) Diabetes Mellitus - Pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) does not apply 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the undersigned) attended the deceased from August 19, 1961 , that (I) (the undersigned) last saw the deceased alive on Sept. 12, 1961 , and that death occurred at 10-13-61 from the causes and on the date stated above. 22a. SIGNATURE Paul Eanet M.D. 22b. DATE SIGNED 10-13-61 22c. PHYSICIAN'S NAME (Type) Paul Eanet 22d. ADDRESS 6727 - 16th St. N.W. D.C. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/16/61 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Prince Georges Co. Md. 24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company ADDRESS Washington, D.C. 25a. REC'D BY REGISTRAR OCT 16 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

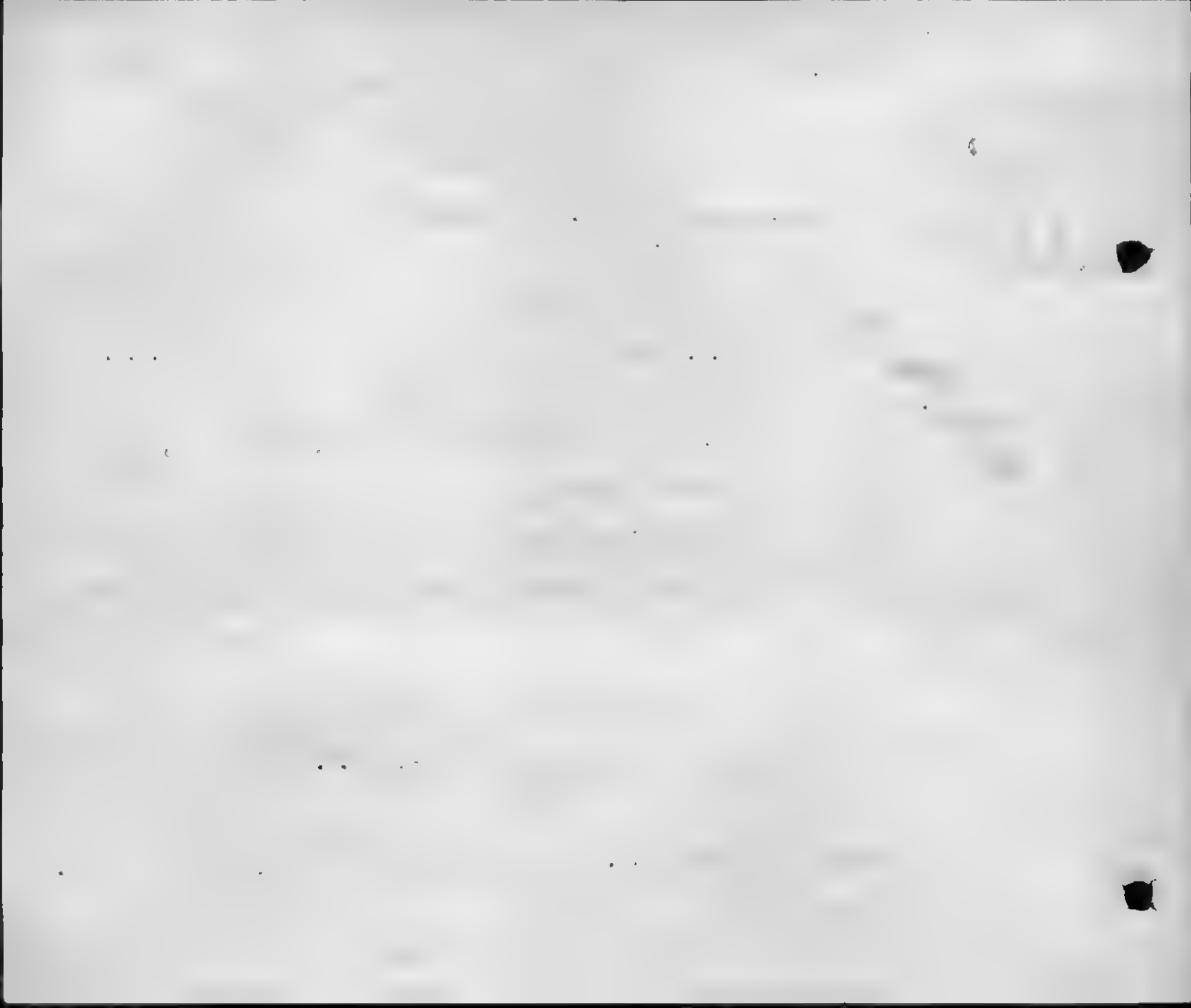
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11522
CERTIFICATE OF DEATH
11507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>81 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>5 Stanley Court</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Bryant</u>		4. DATE OF DEATH <u>October 10 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 29, 1917</u>	
9. AGE (In years last birthday) <u>44 yrs.</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Walsh</u>		14. MOTHER'S MAIDEN NAME <u>Anne Manley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO (b) <u>Myelophthisic anemia</u> DUE TO (c) <u>Metastatic carcinoma of breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>6 months</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 21 1961</u> to <u>October 10 1961</u> , that (I) (we) last saw the deceased alive on <u>October 10 1961</u> , and that death occurred at <u>1:45 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin A. Kirschner</u>		22b. DATE SIGNED <u>Oct 10, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN A KIRSCHNER, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-14-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town or county) (State) <u>Scranton Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 3072-M St. M. W.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



1 FOR STATE HEALTH DEPT.

any delay is necessary, executed within 2 hours after death, should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11508											
1. PLACE OF DEATH a. COUNTY <u>Mont.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>509 Denham Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Joyce T. Bucarich</u>			4. DATE OF DEATH <u>Oct 7 1961</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>July 30, 1933</u>			9. AGE (in years last birthday) <u>28</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		
11. BIRTHPLACE (State or foreign country) <u>#11 West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>OSCAR MINOR MAHONE</u>			14. MOTHER'S MAIDEN NAME <u>NANA STATON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>MR. W. C. BUCARICH #2d.</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + lacunar</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Self-inflicted bullet wound - rt temple</u> (c) <u>Self-inflicted bullet wound - rt temple</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u>			20c. TIME OF INJURY Month, Day, Year <u>6:45 p.m. 10-7-1961</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, hotel, office bldg., etc.) <u>Home</u>			20f. (City or town) <u>Rockville</u>			20g. (County) <u>Montgomery</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>10-7-61</u>		
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						Address (Street, city, town, or county) <u>317 PA. AVE. SE.</u>			22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>10/12/61</u>			22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>			22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA.</u>		
23. FUNERAL DIRECTOR <u>JAMES T. RYAN, Inc.</u>						24a. REC'D BY REGISTRAR <u>Oct 11 '61</u>			24b. REGISTRAR'S SIGNATURE <u>C. H. S. H. H.</u>		



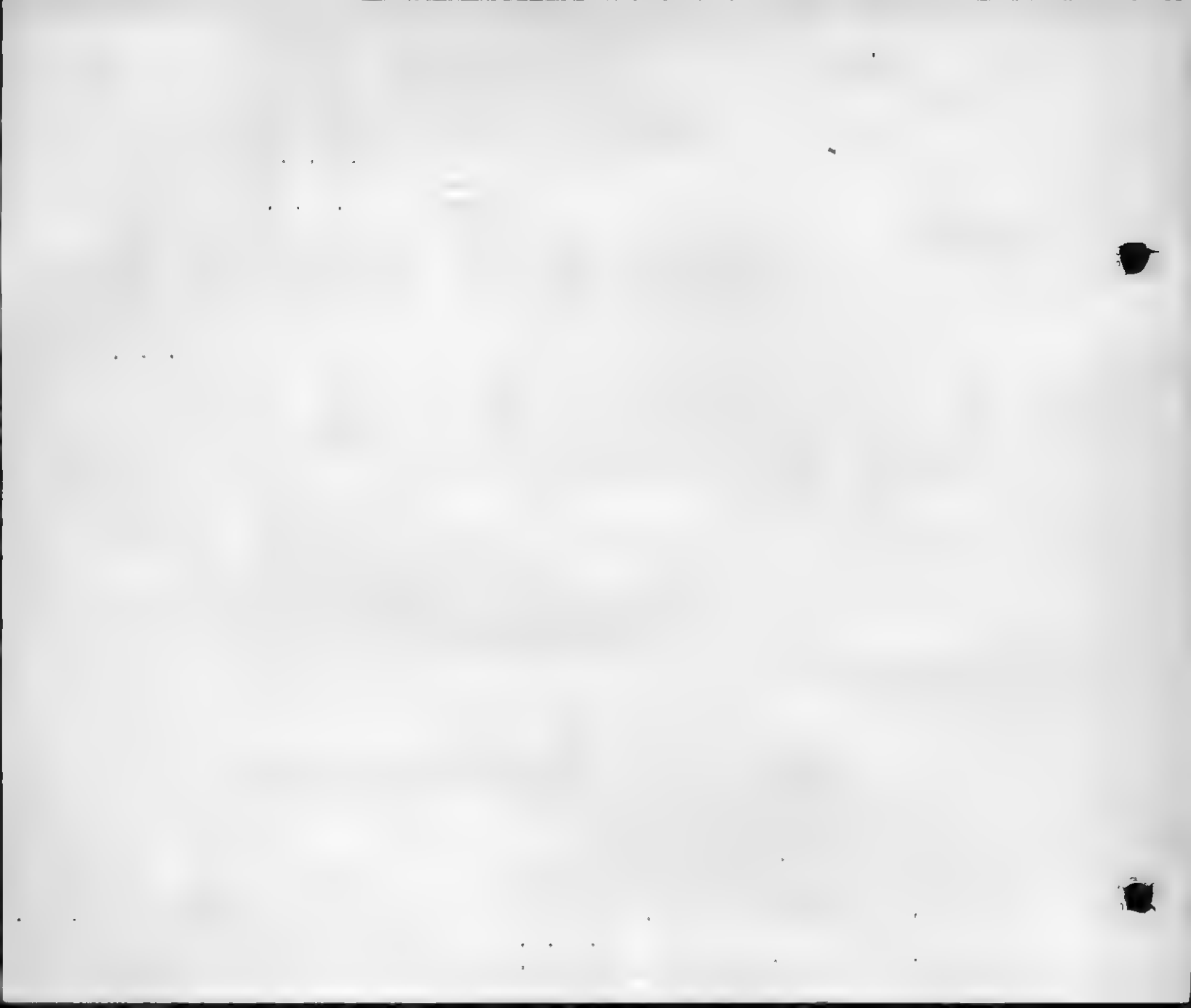
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1150.1

11524

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Washington, D.C. b. COUNTY 4-7-2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eventide Nursing Home		d. STREET ADDRESS 3220 17th St. N.W.	
3. NAME OF DECEASED (Type or print) Josephine Buechler		4. DATE OF DEATH October 20, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/74
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas W. Ryan		14. MOTHER'S MAIDEN NAME Bennetta Onion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441X Enema DUE TO Antenatal nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Antenatal nephrosclerosis, generalized (c) Antenatal nephrosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe hypostrophic osteitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 June 1961 to 20 Oct 1961 , that I last saw the deceased alive on 18 Oct 1961 , and that death occurred at 9:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Seruch T. Kimble		ADDRESS (Street, city or town, state) 927 Pershing Drive, Silver Spring 10-20-61	
PHYSICIAN'S NAME (Type) Seruch T. Kimble		DATE SIGNED 10-20-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/23/61	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR Oct 23 61	
24b. REGISTRAR'S SIGNATURE Carl S. Frank		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11525 Item 9 Film G-10 10/2/61 iwk 11510

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Rural Bethesda** c. LENGTH OF STAY IN b. **33 days**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **USNH, NMHC, Bethesda, Md.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Montgomery**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kensington**
d. STREET ADDRESS **4312 Glenrose St**

3. NAME OF DECEASED (Type or print) **Aloysius Patrick** First Middle Last
4. DATE OF DEATH **BURNS** **Oct 15 1961** Month Day Year
5. SEX **Male** 6. COLOR OR RACE **Cauc** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **17 Mar 96** 9. AGE (In years last birthday) **65 1/2** yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **U.S. Govt.** 11. BIRTHPLACE (County & State, or foreign country) **Washington, D.C.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Aloysius BURNS** 14. MOTHER'S MAIDEN NAME **Margaret HALLEN** Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **yes** (If yes give year or dates of service) **216-40-6588** 16. SOCIAL SECURITY NO. **216-40-6588** 17. INFORMANT **Edna Magdlane BURNS 4312 Glenrose St**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Carcinoma of Lung**
163X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

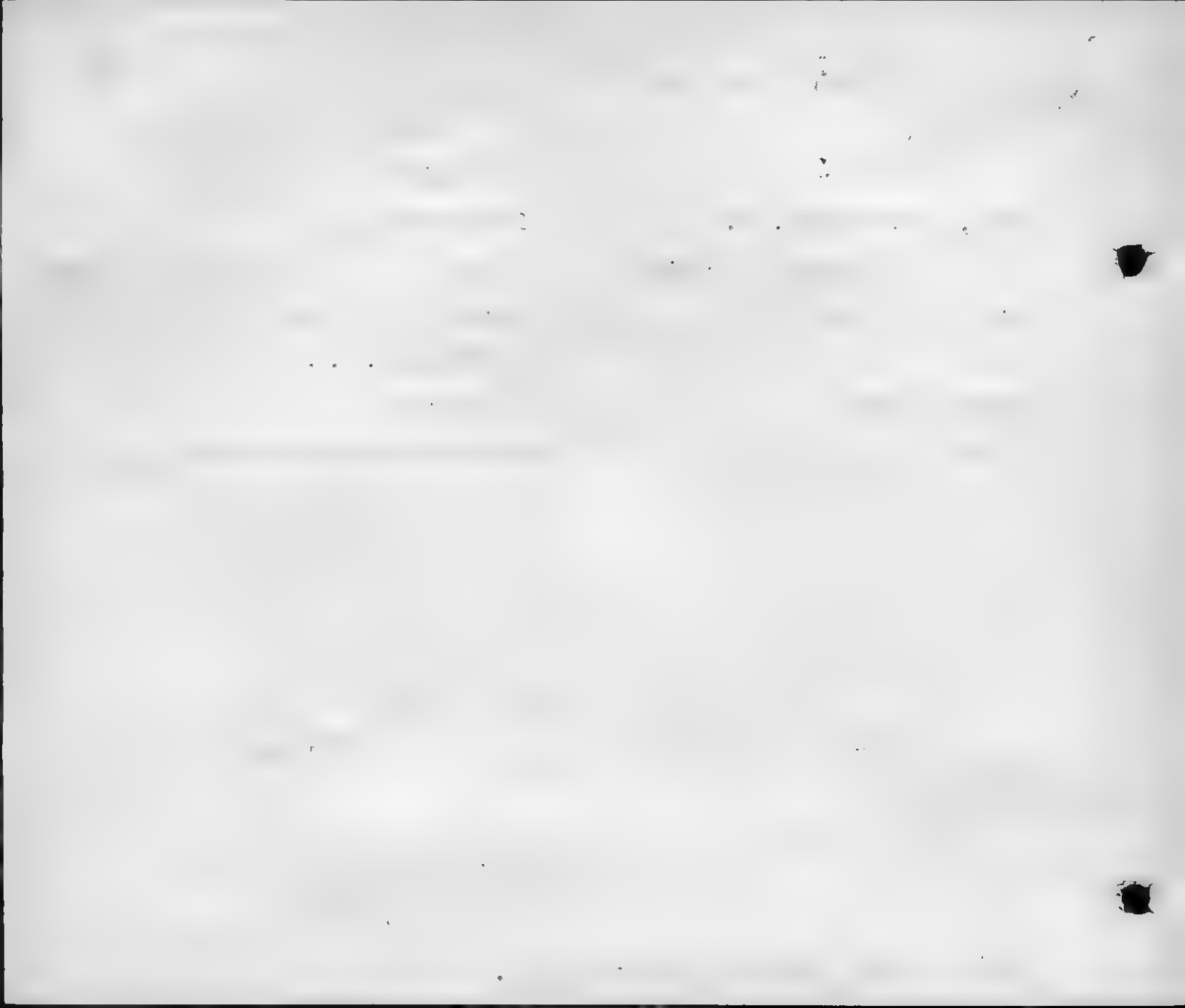
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **11 Sept** 19 **61** to **15 Oct** 19 **61** that (I) **see** last saw the deceased alive on **15 Oct 1961** and that death occurred at **2:10 AM** from the causes and on the date stated above.

22a. SIGNATURE **W. Warren** M.D. 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) **W. WARREN** 22d. ADDRESS **U. S. Naval Hospital, Bethesda, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **10-18-61** 23c. NAME OF CEMETERY OR CREMATORY **Arlington National** 23d. LOCATION (City, town or county) (State) **Arlington Va.**

24. FUNERAL DIRECTOR'S SIGNATURE **Timothy Hanlon** ADDRESS **Washington, D.C.** 25a. REC'D BY REGISTRAR **OCT 17 '61** 25b. REGISTRAR'S SIGNATURE **Arthur S. Thoms**



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

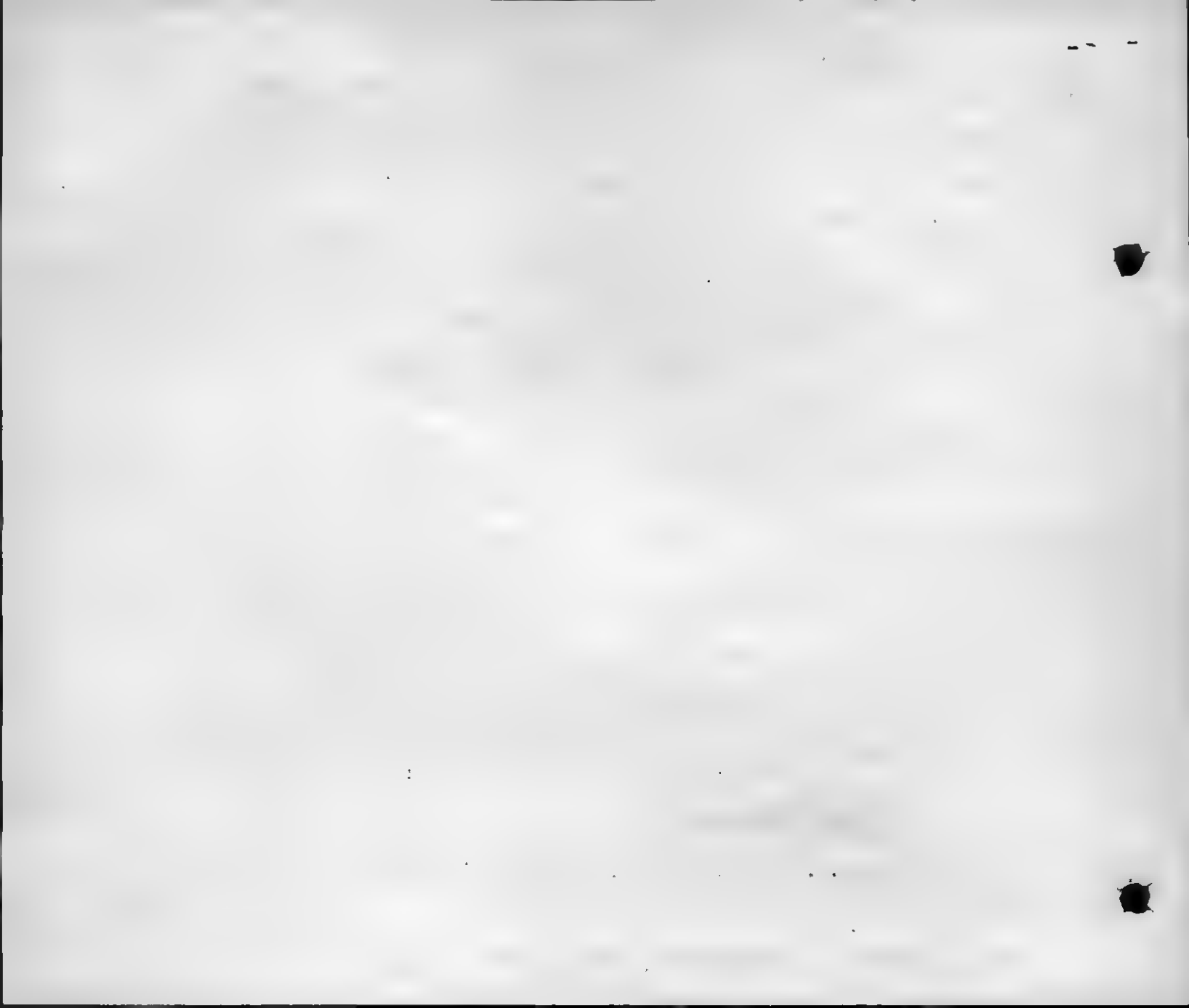
11526

CERTIFICATE OF DEATH

Item 430, Film Q-97 10/20/61 ink

11511

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland		b. COUNTY H.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 10 Williams Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Arthur Valentine Bush		First		Middle		Last		4. DATE OF DEATH Month October		Day 13		Year 1961											
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH September 11, 1999		9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62		Days 62		IF UNDER 24 HRS. Hours 62		Mn 62							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA																	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RT TEMPORAL LOBE INFARCT DUE TO CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 32X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2												INTERVAL BETWEEN ONSET AND DEATH 10 DAYS											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 19		(County) 19		(State) 19													
21. I certify that XX (this hospital) attended the deceased from October 3, 1961 to October 13, 1961 , that (X) (we) last saw the deceased alive on October 13, 1961 , and that death occurred at 8:15 PM from the causes and on the date stated above.																							
22a. SIGNATURE R.W. Magkie M.D.																ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 14 October 1961	
22c. PHYSICIAN'S NAME (Type) R.W. MAGKIE, CAPTAIN, (MC) USN																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61		23c. NAME OF CEMETERY OR CREMATORY Pond Hill Cemetery		23d. LOCATION (City, town or county) Pond Hill, Pennsylvania		(State) 19															
24. FUNERAL DIRECTOR'S SIGNATURE R. J. PUNHERY Funeral Home, Bethesda, Maryland																25a. REC'D BY REGISTRAR OCT 17 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas					



1
FOR STATE
HEALTH DEPT.

any delay is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

23. FUNERAL DIRECTOR

Francis H. Barber

Laytonville, Md.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Address (Street, city, town, or country)

22d. LOCATION (City, town, or country)

(State)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE OCT 26 '61

Caring S. Kenna

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sandy Spring

c. LENGTH OF STAY in lb

Do A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

A. I. Fargnham

3. NAME OF DECEASED
(Type or print)

Arthur Walds Byam

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-29-1884

9. AGE (In years last birthday)

76 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Mass

12. CITIZEN OF WHAT COUNTRY?

U.S.C.

13. FATHER'S NAME

Arthur T. Byam

14. MOTHER'S MAIDEN NAME

Susie Cornelius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of serv. ce)

no

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Nursing Home Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

775-4 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Exposure - Body badly decomposed

Had wound away from nursing home Oct

8 1961. Body found in field about 1/2 mi from home

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

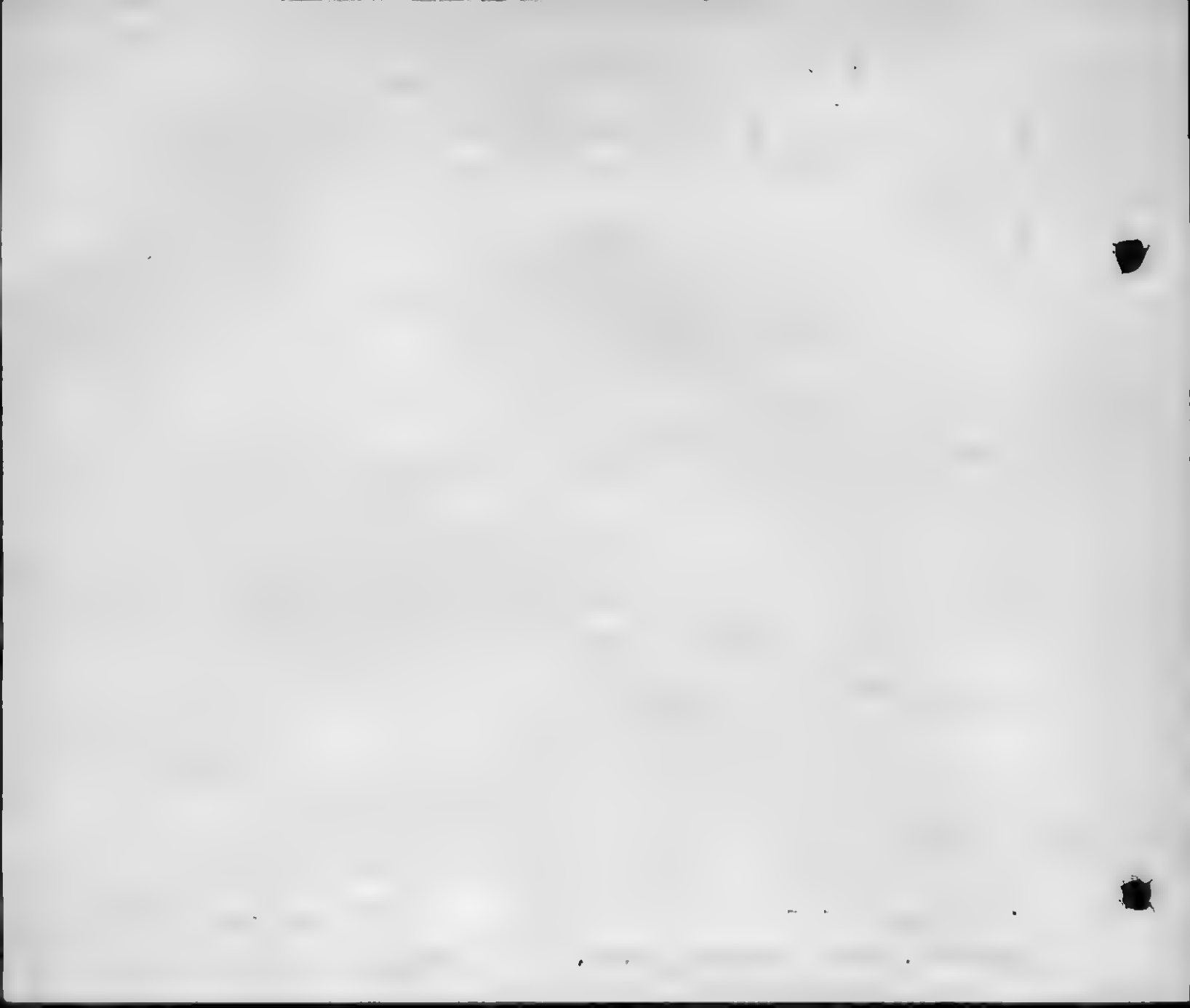
Was also a mental case

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after the death. Page 1 may be retained by the hospital or attending physician. The GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

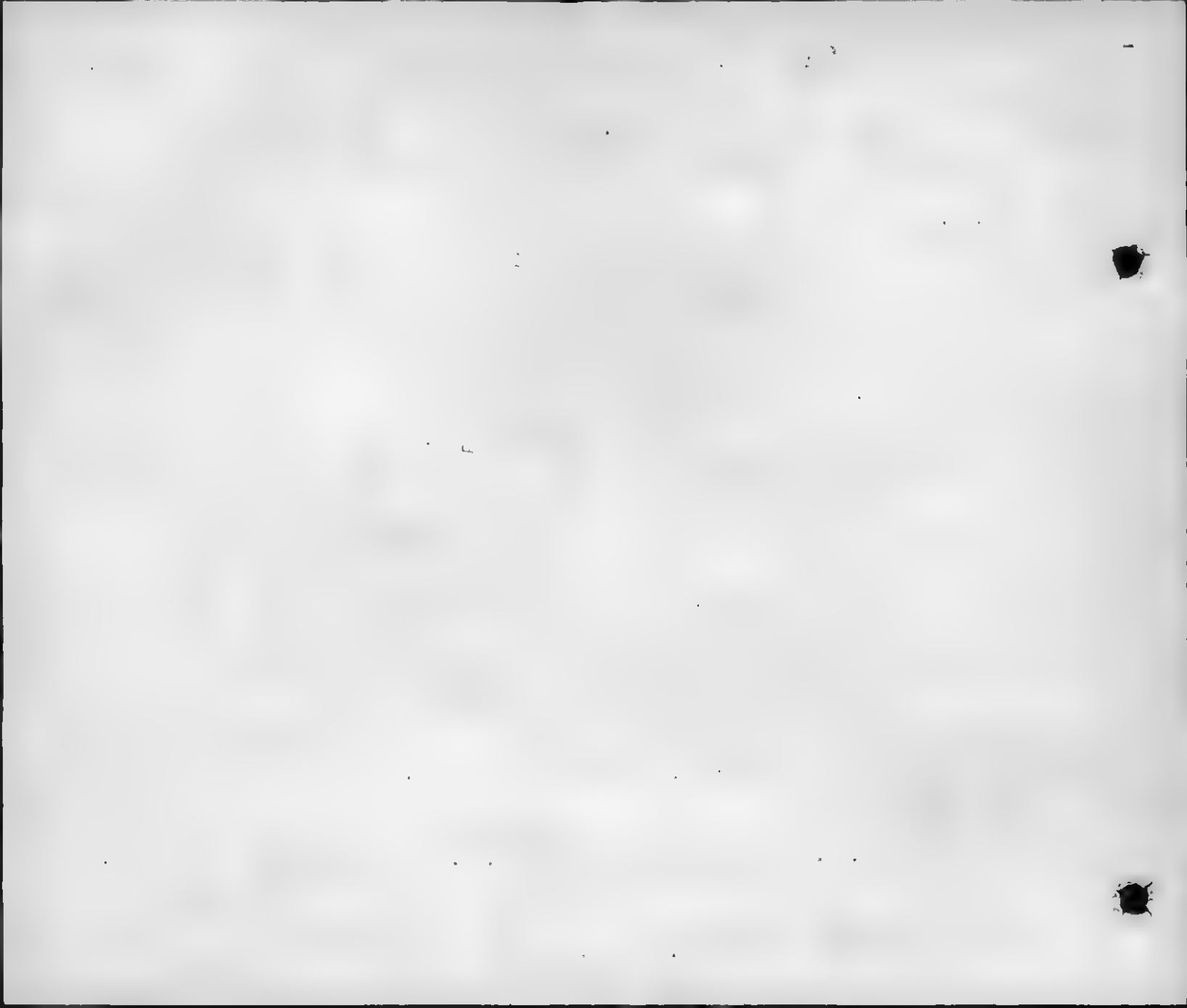
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11528

11513

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> (Rural) <u>6 minutes</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ft. Meade</u> d. STREET ADDRESS <u>7223G Hall Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael</u> <u>Allen</u> <u>Byars</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 19, 1961</u>		9. AGE (In years last birthday) <u>0</u> <u>6</u> IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Mins <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Tony (n) Byars</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Clair Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>FA: Tony Byars, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>77 4-X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>INCOMPETENT CERVIX</u> (c) <u></u> DUE TO (e), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>X</u> (this hospital) attended the deceased from <u>October 19, 1961</u> , to <u>October 19, 1961</u> , that <u>X</u> (we) last saw the deceased alive on <u>October 19, 1961</u> , and that death occurred at <u>2:33AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. R. BOYCE</u> M.D.		22b. DATE SIGNED <u>October 19, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. BOYCE LCDR MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 20, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. GENERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>OCT 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		25c. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Birth Wt. 1 lb 2 oz 152g

11514

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>2 hrs. 11 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>243 EAST MONTGOMERY AVE</u>	
3. NAME OF DECEASED (Type or print) <u>BABY</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>OCTOBER 16, 1961</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>0</u> yrs. <u>10</u> months <u>16</u> days <u>19</u> hours <u>61</u> min.		4. DATE OF DEATH <u>OCTOBER 16, 1961</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY County, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MELVIN "B" CALLOWAY</u>		14. MOTHER'S MAIDEN NAME <u>VERA ELIZABETH HEATH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give year or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>—</u> Address <u>—</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> to <u>10/16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>61</u> , and that death occurred at <u>11</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Emilie C. Black</u> M.D.		22b. DATE SIGNED <u>10/16</u>	
22c. PHYSICIAN'S NAME (Type) <u>EMILIE C. BLACK, MD</u>		22d. ADDRESS <u>5000 ALTA VISTA RD., Bethesda MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>10/18/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>	23d. LOCATION (City, town or county) (State) <u>BETHESDA, MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER, ADMIN. - (per F.B.)</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Moore</u>	
ADDRESS <u>SUBURBAN HOSP. BETHESDA, MD.</u>		DATE <u>OCT 20 '61</u>	

74213X



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

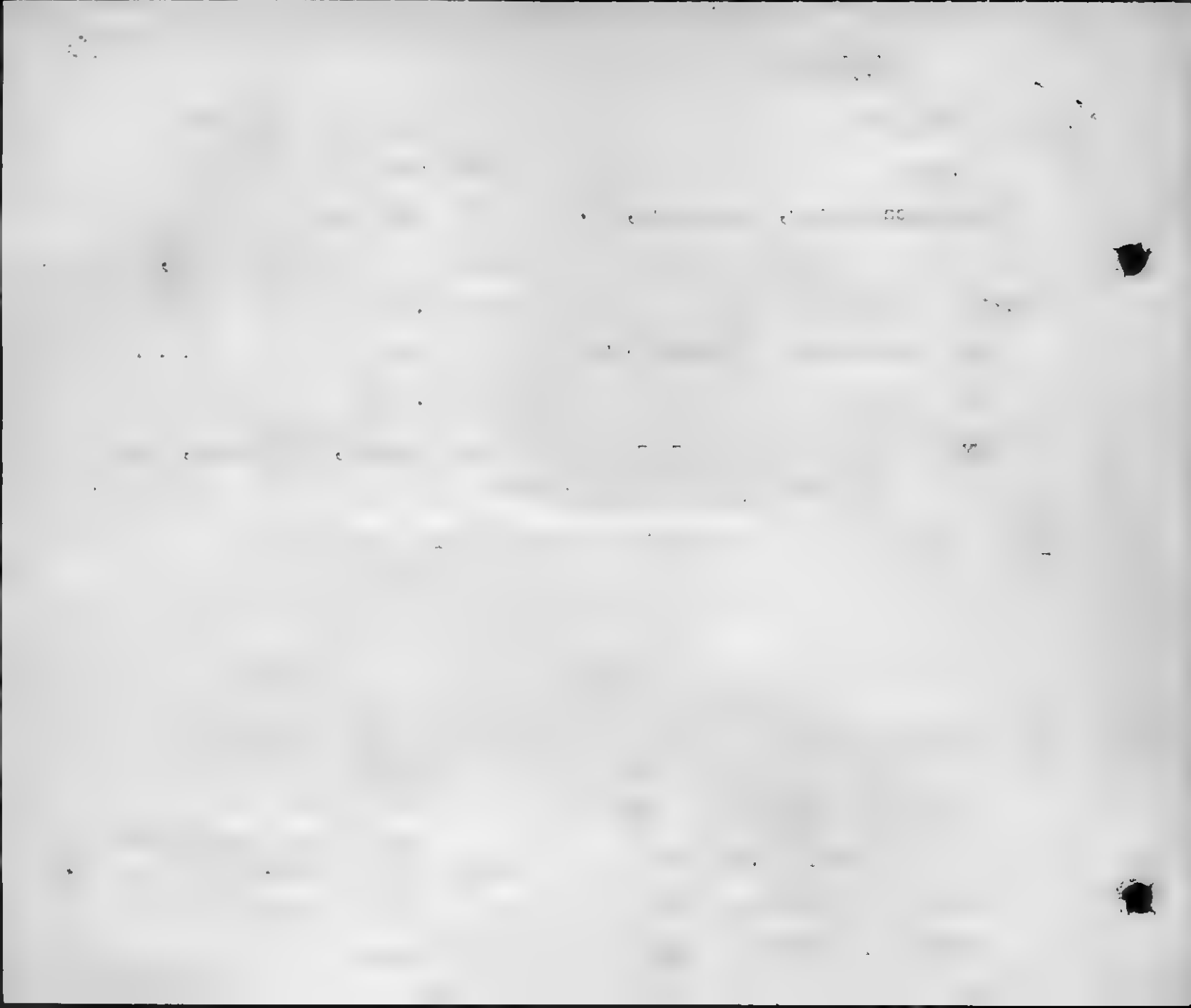
11530

11515

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John d. STREET ADDRESS 6515 78th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Herbert Lee Carter		4. DATE OF DEATH Last October Day 26 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Plant Operator		10b. KIND OF BUSINESS OR INDUSTRY Water plant		9. AGE (In years last birthday) 50 yrs IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.: Hours 0 Min. 0
13. FATHER'S NAME Henry Carter		14. MOTHER'S MAIDEN NAME Birdie V. Loy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 578-32-4351		
17. INFORMANT The Medical Records				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____				
INTERVAL BETWEEN ONSET AND DEATH 10 minutes 7 years				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that X (this hospital) attended the deceased from October 21, 1959 to October 26, 1961 , that X (we) last saw the deceased alive on October 24, 1961 , and that death occurred at 5:30 PM from the causes and on the date stated above.				
22a. SIGNATURE William A. Pettinger		22b. DATE SIGNED October 27, 1961		
22c. PHYSICIAN'S NAME (Type) William A. Pettinger		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/29/61	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town or county) Burtonsville, Maryland (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 30 '61		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Not a medical examiner's case



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

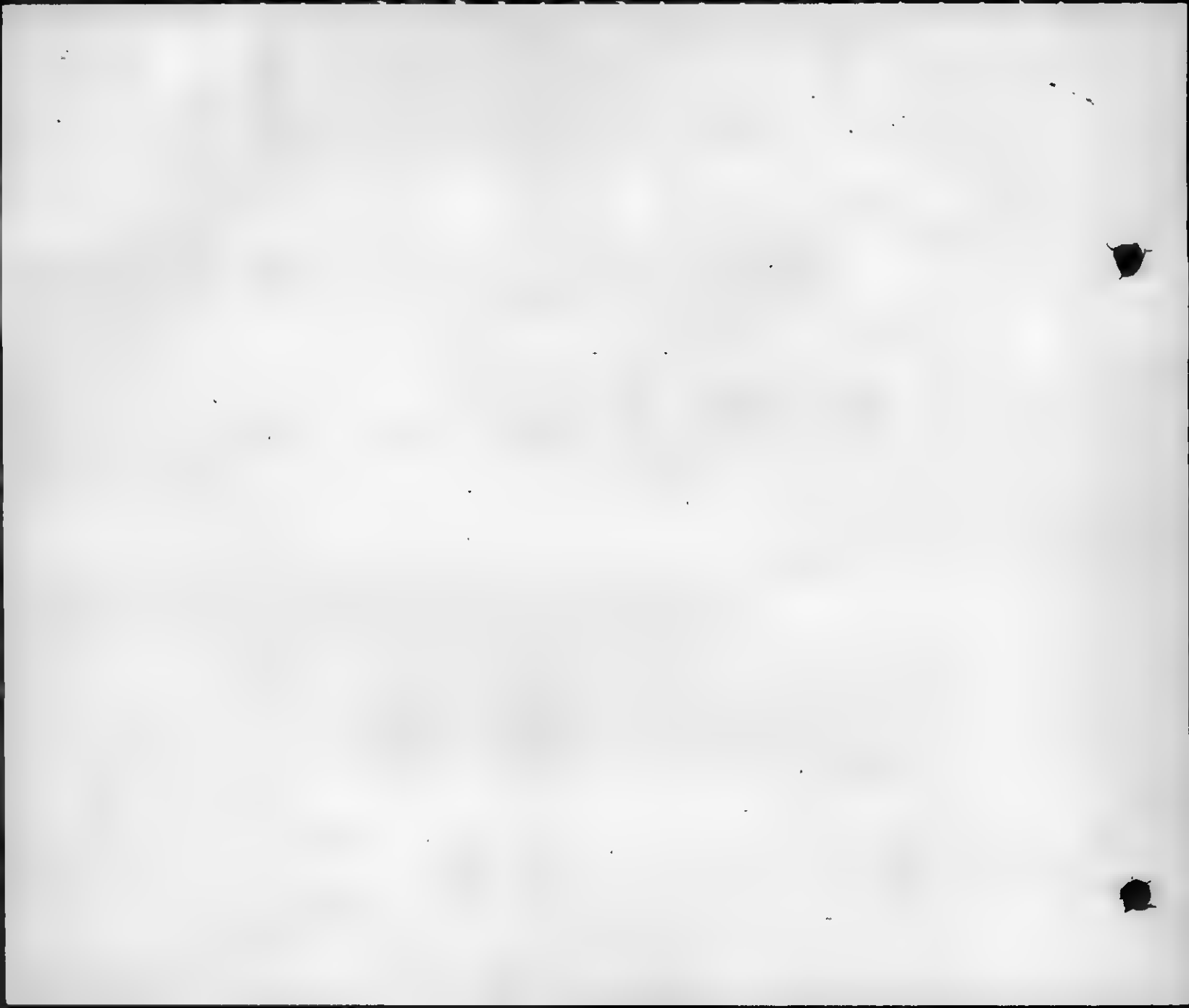
11531

11516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 mo. 1 day 1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		4-7X-23	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				d. STREET ADDRESS <u>2631 Naylor Rd. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Alma Mae Casebeer</u>				4. DATE OF DEATH Month Day Year <u>Oct. 23 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard W. Frye</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mossburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>..</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adhesions</u> DUE TO (c) <u>Carcinoma of the Sigmoid</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilat Sciatica</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/1955</u> to <u>10/23/1961</u> , that (I) (we) last saw the deceased alive on <u>10/23/1961</u> , and that death occurred at <u>2:19</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>Robert A. Hare</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>		22d. ADDRESS <u>7600 Carroll Ave. Tak. PR, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros 1661 Good Hope Rd</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5516 Wilson Lane</u>		d. STREET ADDRESS <u>2475 Va. Ave. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>H</u> Last <u>CHAPPELEAR</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1884</u>
9. AGE (In years for birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Higgenbotham</u>		14. MOTHER'S MAIDEN NAME <u>Sara (Sally) Cochran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS S. HUBERMAN</u>		Address <u>5516 WILSON LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatous - original site undetermined.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>199X</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Oct 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 17, 1961</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. O'Doman</u> M.D.		22b. DATE <u>Oct 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. O'DOMAN</u>		22d. ADDRESS <u>1746 M St. NW - WASH DC</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Huns</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	
DATE <u>OCT 20 '61</u>			

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11534											
11519											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2502 Henderson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Hill</u> Last <u>Childers</u>						4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1961</u>					
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>June 23, 1894</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service man</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Richard Apperson Childers</u>						14. MOTHER'S MAIDEN NAME <u>Jane Combs</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>WIFE: Mrs. Pauline L. Childers, Same as #2</u>					
17. INFORMANT <u>WIFE: Mrs. Pauline L. Childers, Same as #2</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suffocation</u> DUE TO <u>aspiration of vomitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 month</u> Years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hosp., Bethesda, Montg., Md.</u> 20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 5, 1961</u> to <u>October 11, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 11, 1961</u> , and that death occurred at <u>2:49 PM</u> , from the causes and on the date stated above											
22a. SIGNATURE <u>Paul G. Linaweaver, LCDR MC USN</u> 22c. PHYSICIAN'S NAME (Type or print) <u>PAUL G. LINAWEAVER, LCDR MC USN</u>						22b. DATE <u>11 October 1961</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>16 Oct 1961</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES T. RYAN</u> 24b. ADDRESS <u>Funeral Home, Washington, D. C.</u>						25a. REC'D BY REGISTRAR <u>OCT 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the hospital or attending physician retain the original of the certificate for 4 years. The law further requires that the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

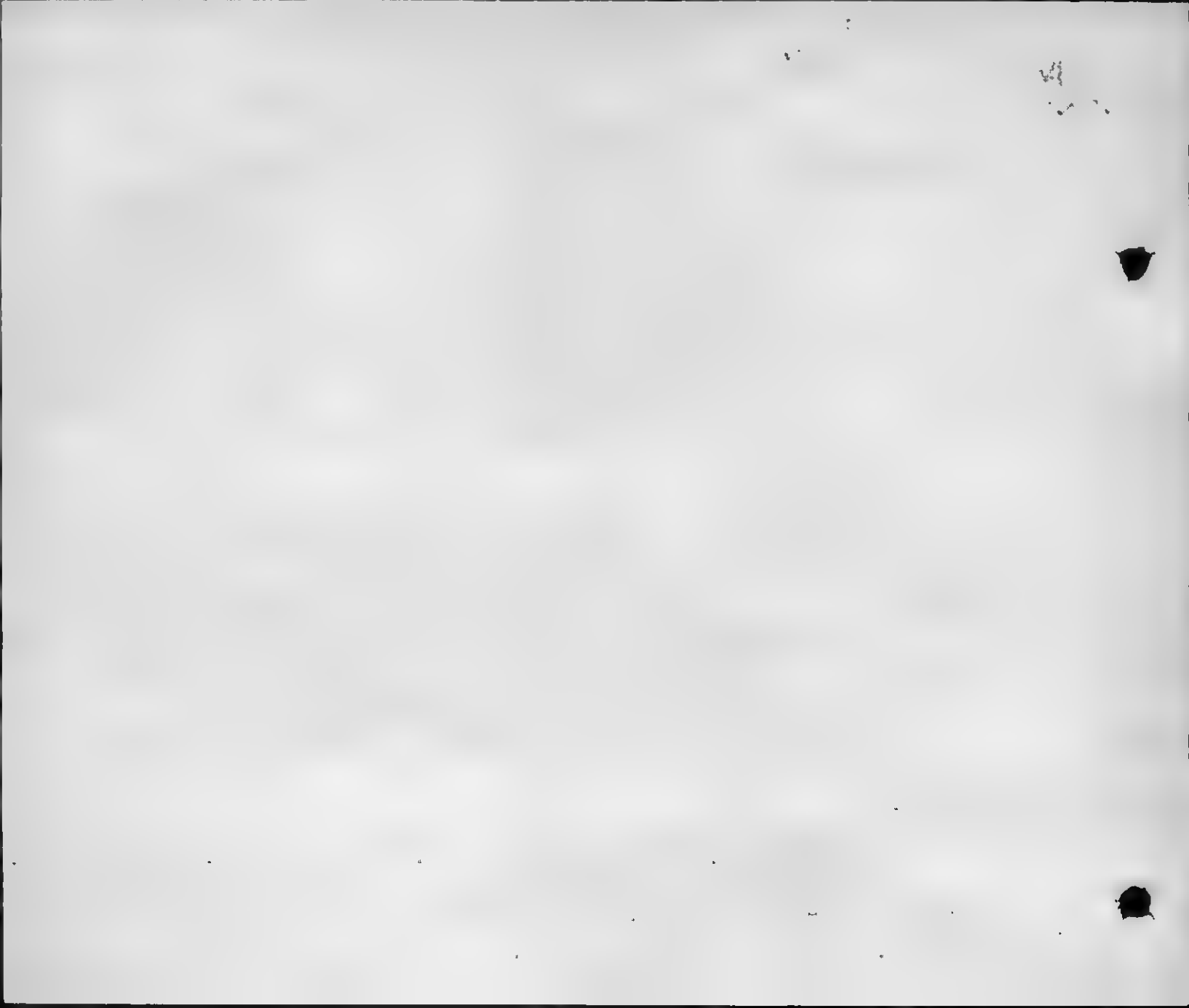
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11535

CERTIFICATE OF DEATH

11520

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN b. <i>10 hrs 45 min</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>1409 Baltimore Rd.</i>											
3. NAME OF DECEASED (Type or print) <i>Charles Patrick Clark</i> First Middle Last 4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/19/1946</i>									
9. AGE (In years last birthday) <i>67</i> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. DATE OF DEATH <i>Oct. 5 1961</i>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile Maryland</i>				11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles Mason Clark</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Lamb</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, unknown) (If yes, give year or dates of service) <i>Marine Guard 220-07-3191</i>							
16. SOCIAL SECURITY NO. <i>220-07-3191</i>				17. INFORMANT <i>Geneva Clark</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>coronary occlusion</i>				DUE TO <i>anemia from bleeding esophageal varices</i>				INTERVAL BETWEEN ONSET AND DEATH <i>22 hours</i>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>congestive heart failure</i>				DUE TO <i>Lance cirrhosis</i>				15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <i>congestive heart failure</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>March 1957</i> to <i>Oct. 5 1961</i> , that (I) <i>no</i> last saw the deceased alive on <i>Oct. 5 1961</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.								22a. SIGNATURE <i>Stephen C. Cromwell</i> M.D.				22b. DATE SIGNED <i>10-6-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>STEPHEN C. CROMWELL</i>				22d. ADDRESS <i>615 W. Montgomery Ave., Rockville, Md.</i>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10-9-61</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>							
23d. LOCATION (City, town or county) <i>Montgomery Co., Maryland</i>				23e. REC'D BY REGISTRAR <i>Robert A. Pumphrey</i>				23f. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>				24a. ADDRESS <i>Bethesda, Md.</i>				24b. DATE <i>OCT 13 '61</i>							



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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death, my delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10-28-61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11521

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs</u>				d. STREET ADDRESS <u>288 Dill Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beeth mill Rd</u>							
3. NAME OF DECEASED (Type or print) <u>Herbert A Clark</u>				4. DATE OF DEATH <u>Oct 28 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 - 1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herbert F Clark</u>		14. MOTHER'S MAIDEN NAME <u>Flora Arnold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Ruth Clark (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cornary occlusion</u>				DUE TO (b) <u>Coronary occlusion</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)				DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10-28-61</u>			
Address (Street, city, town, or county)				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 31 '61</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>			



TO VOUCHER ON ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death of the deceased. The attending physician and coroner must be filled in by the funeral director. Page 4 may be retained by the hospital. After this certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

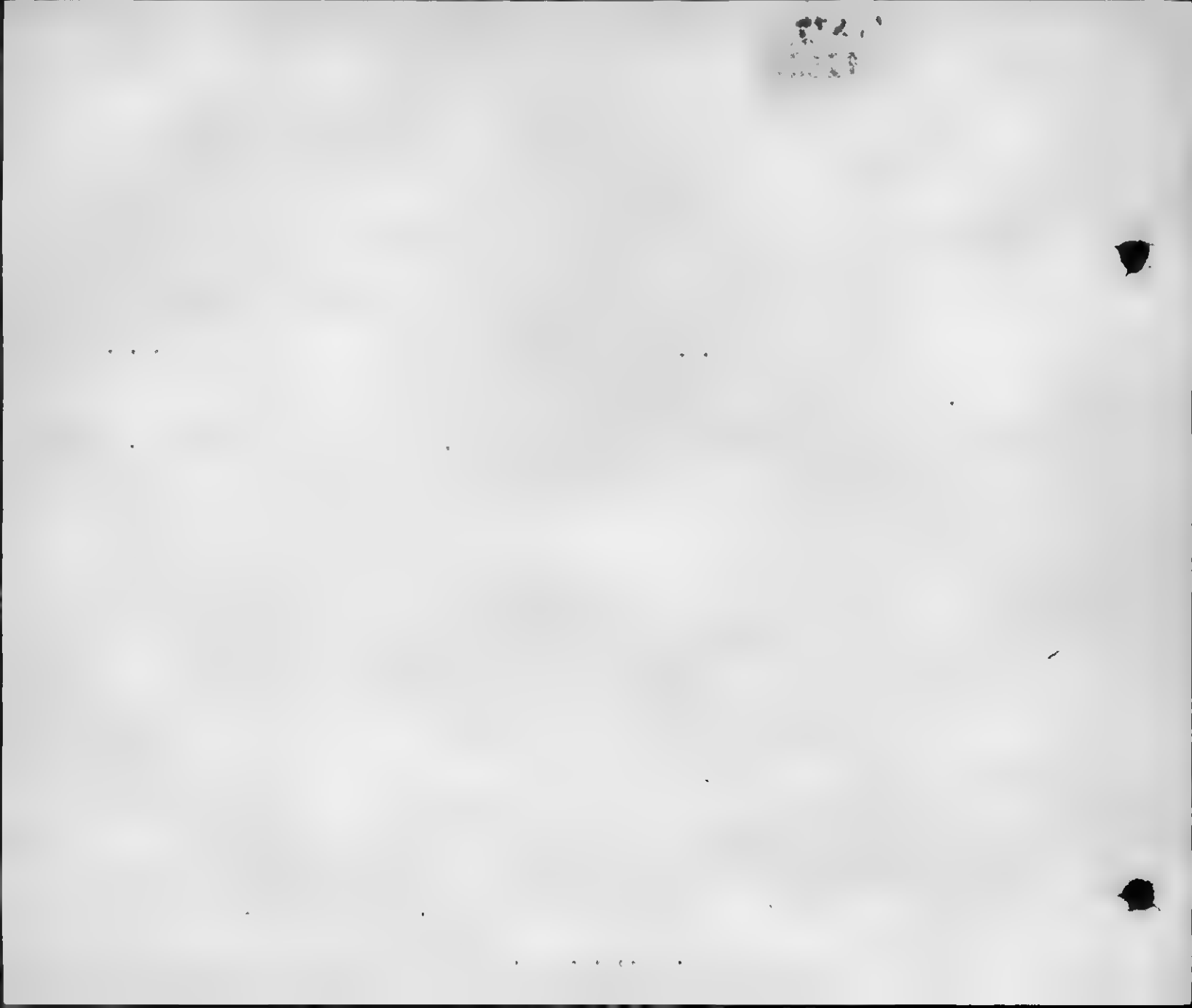
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11537

11522

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1124 Noelcrest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Walter Clark</u> First Middle Last		4. DATE OF DEATH <u>10 17 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/07</u> Month Day Year
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>L. Frank Clark</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Belle Venable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>157X</u>	
17. INFORMANT <u>Gladys M. Clark</u> Address <u>1124 Noelcrest Dr. Sil Sp</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Pancreatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) <u>3 months</u> (c) <u>Interval between onset and death</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>19</u> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1961</u> to <u>10/17/1961</u> , that (we) last saw the deceased alive on <u>10/13/1961</u> , and that death occurred at <u>740A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Earle B. Thompson</u> 22c. PHYSICIAN'S NAME (Type) <u>EARLE B THOMPSON MD</u>		22b. DATE SIGNED <u>10/17/61</u> 22d. ADDRESS <u>1025 Vermont Ave NW, Wash, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga. Ave., N.W. Wash., DC</u>		25a. REC'D BY REGISTRAR <u>OCT 20 61</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Form 3-59 11/6/61 1wk

11538

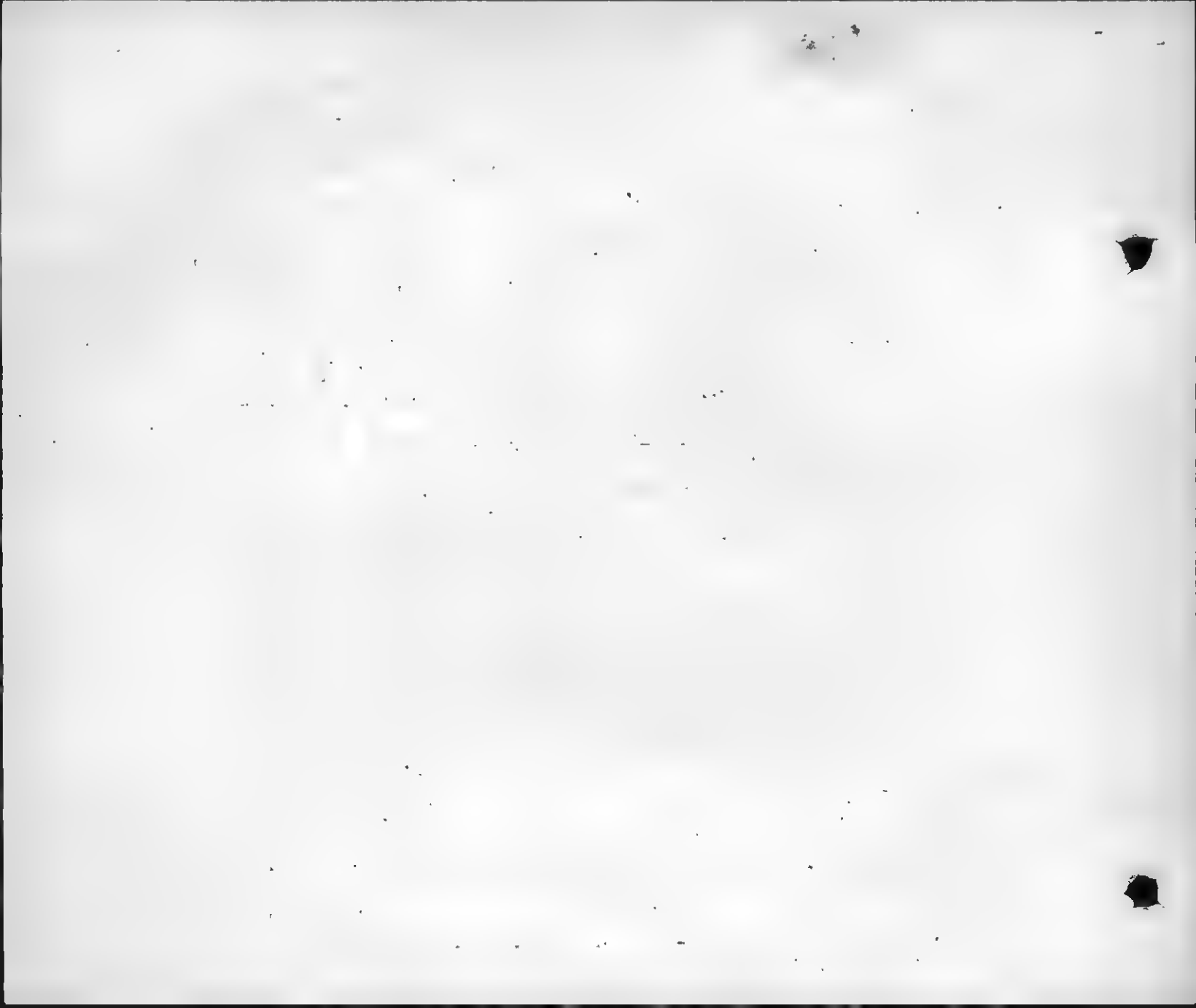
CERTIFICATE OF DEATH

Reg. Dist. No.

11523

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b/ 1 day 9 hrs. Redland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1 d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Margaret (NMI) Cline First Middle Last				4. DATE OF DEATH October 23, 19 61 Month Day Year											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 29 1922 Jan 29, 1922		9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Plantation Bn. Maryland				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Edward Johnson						14. MOTHER'S MAIDEN NAME Ethel Carolisle									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-24-9565				INFORMANT Shirley Laurette (daughter) Address Same as Above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445 Berber Vascular accident DUE TO (b) Religant hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)												INTERVAL BETWEEN ONSET AND DEATH 30 hrs 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 15, 1961 , to Oct 23, 1961 , that I last saw the deceased alive on Oct 22, 1961 , and that death occurred at 12:50 AM from the causes and on the date stated above.															
ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. DATE SIGNED 10/23/61												ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) John S. Rogers 1919 Seminary Road, Silver Spring, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/26/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn				22d. LOCATION (City, town, or county) (State) Rockville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland												24a. REC'D BY REGISTRAR DATE OCT 25 '61		24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11524

11539

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OWN HOME		d. STREET ADDRESS 3500 DECATUR AVE.	
3. NAME OF DECEASED (Type or print) First ADA Middle WRIGHT Last COCHRAN		4. DATE OF DEATH Month OCT. Day 22 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 9, 1872
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BUTLER, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Wright		14. MOTHER'S MAIDEN NAME Hannah Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Helen C. Mason		Address 3500 DECATUR AVE. KENSINGTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. arteriosclerosis; hypertension DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 20 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 8, 1959 , to Oct. 22, 1961 , that I last saw the deceased alive on Oct. 20, 1961 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip H. Varner		ADDRESS (Street, city or town, state) 10620 Ga. Ave., Wheaton, Md.	
PHYSICIAN'S NAME (Type) PHILIP H. VARNER		DATE SIGNED 10-22-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF OCT. 25, 1961	
22c. NAME OF CEMETERY OR CREMATORY Ledar Hill Crematory		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE GREEN FUNERAL HOME		ADDRESS HERNDON, VA.	
24a. REC'D BY REGISTRAR DATE OCT 26 '61		24b. REGISTRAR'S SIGNATURE William S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



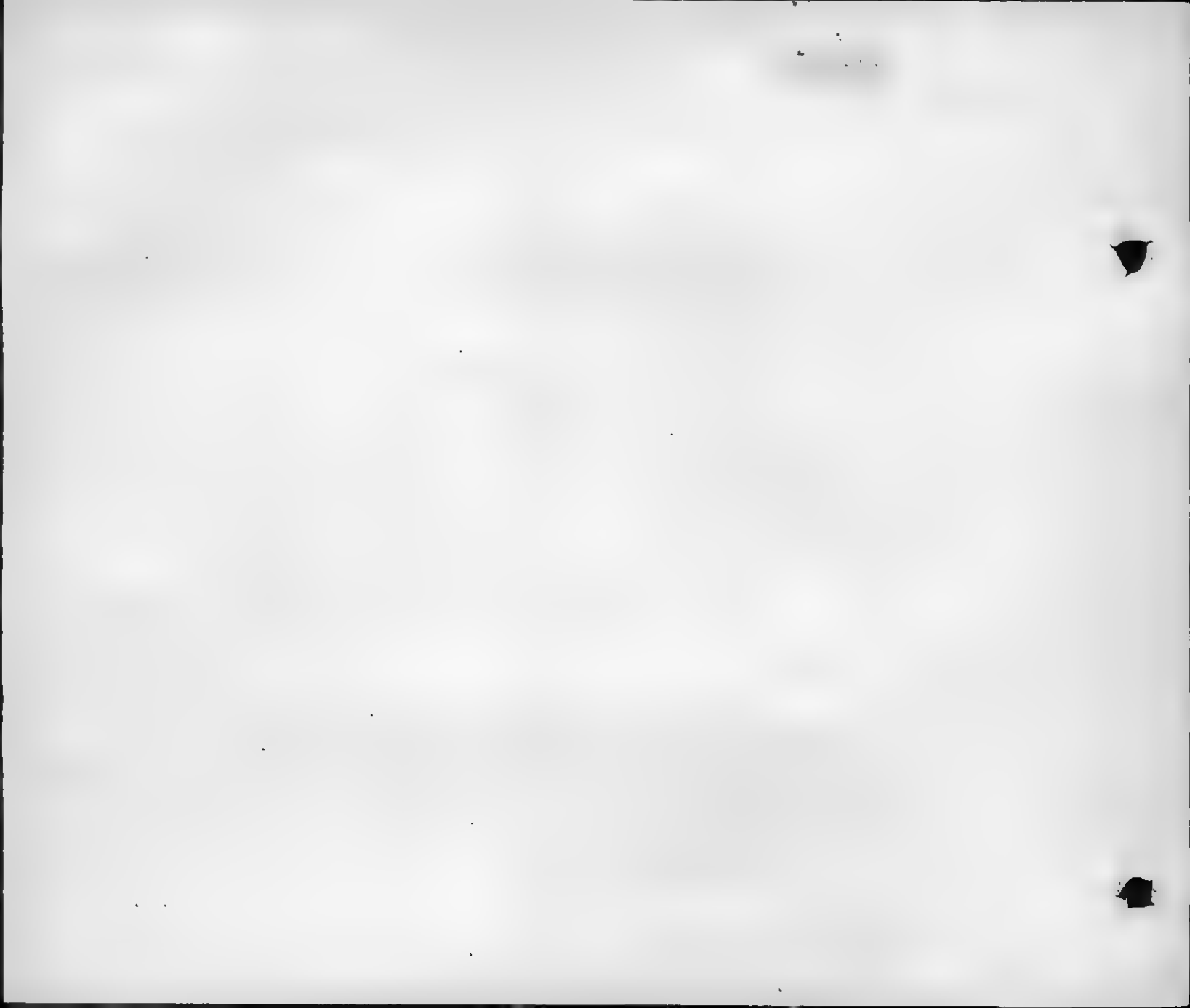
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11540

11525

1 PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD		c. LENGTH OF STAY IN 1b 10/23/61		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MANOR NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON DC		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The Woodner - Washington, D.C.		d. STREET ADDRESS 3636 -16th. St/ M/W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GERTRUDE		First COLLAMER		Last COLLAMER		4. DATE OF DEATH Month OCTOBER		Day 23	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 6, 1868		9. AGE (In years last birthday) 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME (unknown) Jochum		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO —		17. INFORMANT PATIENT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIOSCLEROSIS CORONARY ARTERIES DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 3 HOURS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) —		20g. (County) —		20h. (State) —		21. I certify that (I) (this hospital) attended the deceased from APRIL 1960 , to OCT. 23, 1961 , that (I) (we) last saw the deceased alive on 10/23, 1961 , and that death occurred at 10:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE Lawrence A. Rapee		22b. DATE SIGNED 10/23/1961		22c. PHYSICIAN'S NAME (Type) LAWRENCE A. RAPEE, MD		22d. ADDRESS 1150 CONN AVE NW WASH., D.C.		22e. DATE 10/23/1961	
23a. BURIAL, CREMATION, REMOVAL Crementation		23b. DATE THEREOF 10-24-61		23c. NAME OF CEMETERY OR CREMATORY Lee's crematorium		23d. LOCATION (City, town, or county) Washington D.C.		(State) —	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Lee & Sons		24a. ADDRESS 300 H. St N.E.		25a. REC'D BY REGISTRAR DATE OCT 26 '61		25b. REGISTRAR'S SIGNATURE C. L. S. Kline			



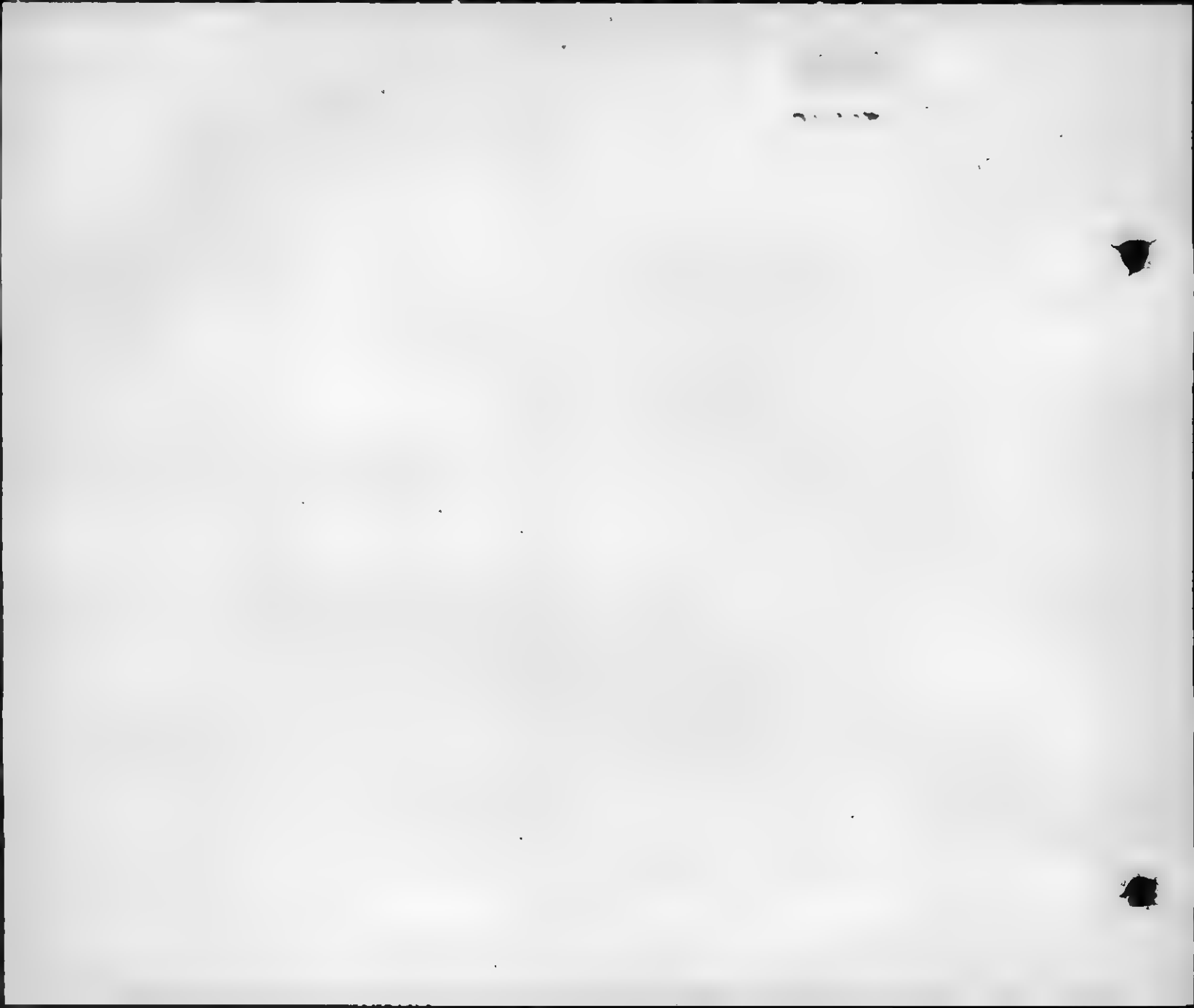
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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11541

CERTIFICATE OF DEATH

11526

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY, IN 1b <i>4 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		16 SEP - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitorium</i>				d. STREET ADDRESS <i>4607 69th Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>K</i> Last <i>COOLEY</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>11</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 June 1870</i>		9. AGE (In years lost birthday) <i>91</i> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jonathan Ryden</i>				14. MOTHER'S MAIDEN NAME <i>Jane T. Eldridge</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>—</i>		17. INTERMENT Address <i>Clifton Cooley Hyattsville Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Hemorrhage</i> DUE TO <i>Rheumatic Fever</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO <i>—</i> (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>5/18/61</i> to <i>10/11/61</i> 19 that (I) (we) last saw the deceased alive on <i>10/11/61</i> 19 and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above							
22a. SIGNATURE <i>SAM Allen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>SAM Allen</i>				22d. ADDRESS <i>Kensington Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-15-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cranton</i>		23d. LOCATION (City, town, or county) (State) <i>Rhode Island</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Baacke</i>				25a. RECEIVED BY REGISTRAR DATE <i>OCT 16 61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11542

11527

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 3days 10-hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 13 Brooks Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jessie Cecil Crawford	4. DATE OF DEATH Month 10 - Day 20 Year 1961	5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 10-2-84 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown, house wife 10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Everett H. Cecil 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME Julia May Thompson 16. SOCIAL SECURITY NO. hospital records 17. INFORMANT hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION (b) CORONARY ARTERIOSCLEROSIS (c) 12/01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12/01 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year 1961 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10-20 20f. (City or town) Gaithersburg (County) Md. (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 1961 to 10-20, 1961, that (I) (we) last saw the deceased alive on 10-20, 1961, and that death occurred at 2:30 M. from the causes and on the date stated above.				
22a. SIGNATURE Dr. L. I. Leal, M.D.		22b. DATE SIGNED 10-24-61		
22c. PHYSICIAN'S NAME (Type) Dr. L. I. Leal, M.D.		22d. ADDRESS Gaithersburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-23-61		
23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town or county) Gaithersburg Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		25a. REC'D BY REGISTRAR OCT 24 '61		
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. REGISTRAR'S SIGNATURE Arthur L. Thomas		

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11528

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>R.F.D. #3 Box 65A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Cromwell Jr.</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1917</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. AGE (In years last birthday) Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		11. BIRTHPLACE (State & foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Edward Cromwell Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Louise Palmer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes Army-World War 2</u>	
16. SOCIAL SECURITY NUMBER <u>Un-known</u>		17. ADDRESS <u>Ma mie E. Holland / Sister Rt2 Frederick Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for terminal disease and conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Laceration ant. descending coronary artery</u> DUE TO <u>Crushed chest</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Passenger in car which struck tree</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.) <u>Passenger in car which struck tree</u> 20c. TIME OF INJURY Month, Day, Year <u>5:30 p.m. 10-18-61</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> 20f. (City or town) (County) (State) <u>Rockville Monty Md</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DATE SIGNED <u>10-15-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-18-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopehill</u>		22d. LOCATION (City, town, or country) (State) <u>Frederick, Co Md</u>	
23. FUNERAL DIRECTOR <u>C.E. Hicks, 111</u>		24a. REC'D BY REGISTRAR <u>OCT 20 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11544

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11523

Item 2 Film G297 10/24/61 mh

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY in 1b <i>3 hr</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont</i>		d. STREET ADDRESS <i>108-2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ada Blanche Crouse</i>		4. DATE OF DEATH Month Day Year <i>10 17 19 61</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-11-73</i>		9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer</i>		13. FATHER'S NAME <i>John L. Crouse</i>		14. MOTHER'S M.A.DEN NAME <i>Mary H. Sefton</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Washington Sanatorium & Hospital</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>420.11</i> DUE TO (c) <i>420.11</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>10-20-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>United Brethren</i>		22d. LOCATION (City, town, or country) (State) <i>Thurmont</i>		23. FUNERAL DIRECTOR <i>Edgar J. Fischer</i>		24. REC'D BY REG STRAR <i>10-20-61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11545											
11530											
Item 21 from 6-27-61 10/1/61 iwk											
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN b. 28 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 807 North 25th Street				f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Morgan		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 21, 1894		9. AGE (In years last birthday) 66 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Office				11. BIRTHPLACE (County & State or foreign country) Missouri			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles M. Culver				14. MOTHER'S MAIDEN NAME Louella Elliot			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 491-10-2075				17. INFORMANT The Medical Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 710.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Heart Failure (c) Scleroderma				INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 months 1 Year				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) St. Joseph, Missouri				20g. (County) Missouri			
21. I certify that (I) (this hospital) attended the deceased from September 5, 1961, to October 3, 1961, that (I) (we) last saw the deceased alive on October 3, 1961, and that death occurred at 11:50AM from the causes and on the date stated above.											
22a. SIGNATURE Thomas S. Vates Jr.				22b. DATE 10-3-61				22c. PHYSICIAN'S NAME (Type) Thomas S. Vates Jr. M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e. REC'D BY REGISTRAR DATE OCT 5 '61				22f. REGISTRAR'S SIGNATURE Arthur S. Hanks			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/4/1961				23b. DATE THEREOF 10/4/1961				23c. NAME OF CEMETERY OR CREMATORY 1756 In. Ave. W.D.C.			
23d. LOCATION (City, town or county) St. Joseph, Missouri				23e. (State) Missouri				23f. (County) Missouri			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Doss											
24b. ADDRESS 1756 In. Ave. W.D.C.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11546 CERTIFICATE OF DEATH 11531											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Res. dance before adm. ssion) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 720 Dale Drive							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b Since 9/10/61				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home			
3. NAME OF DECEASED (Type or print) LOUIS MARSHALL CUVILLIER SR.		4. DATE OF DEATH Month October Day 24 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1882	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed Dental Surgeon				10b. KIND OF BUSINESS OR INDUSTRY Petersburg, Va.				11. BIRTHPLACE (County & State, or foreign country) U. S. A.			
13. FATHER'S NAME James Freeland				14. MOTHER'S MAIDEN NAME Augusta Marshall				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-38-1431				17. INFORMANT Mrs. Anna V. Cuvillier, 720 Dale Drive, SS., Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 14 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Silver Spring		20g. (County) Montgomery		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from FEB. 1961 to 23 OCT. 1961 , that (I) (we) last saw the deceased alive on 23 OCT. 1961 , and that death occurred at 5:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE L. Marshall Cuvillier, Jr.				22b. DATE SIGNED 10/24/61				22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.			
22d. ADDRESS 1407 Woodside Parkway, Silver Spring, Md.				22e. REC'D BY REGISTRAR DATE OCT 25 '61				22f. REGISTRAR'S SIGNATURE Arthur S. House			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 26, 1961				23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			
23d. LOCATION (City, town or county) Washington, D. C.				23e. (State) D. C.				23f. (Country) U. S. A.			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska				24a. ADDRESS Warner E. Pumphrey, Inc., Silver Spring, Md.				24b. (City, town or county) Silver Spring, Md.			
24c. (State) Md.				24d. (Country) U. S. A.				24e. (Other) 			

10/1/77



11547

CERTIFICATE OF DEATH

Reg. Dist. No. 11532

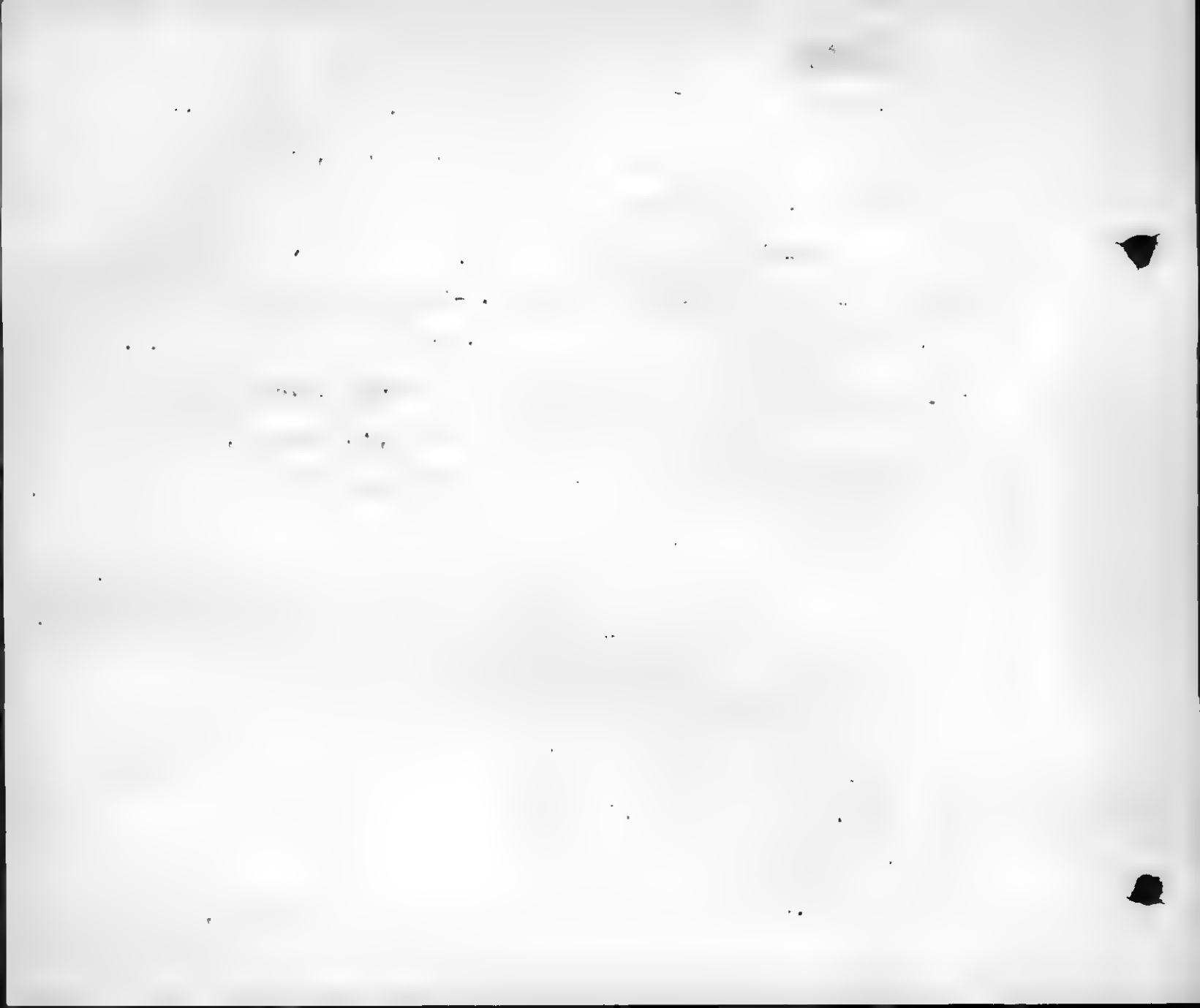
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander, Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Natie Middle DARBY Last DARBY		4. DATE OF DEATH Month October Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5-1877
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Dyson		14. MOTHER'S MAIDEN NAME Catherine Pyles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Address Dunbar Darby, Beallsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) intermittent heart disease DUE TO (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days - 5 years - 10 years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1950 to Oct 18, 1961 , that I last saw the deceased alive on Oct 16, 1961 , and that death occurred at 8:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Fawcett M.D.			
PHYSICIAN'S NAME (Type) John Fawcett			
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 20-1961	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Md
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR Barneville, Md. DATE OCT 20 '61	
24b. REGISTRAR'S SIGNATURE Charles E. Hines			

4 hours after death. Page 4

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11538

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8906 Peerm Ave</u>		e. STREET ADDRESS <u>18906 Peerm Ave</u>	
3. NAME OF DECEASED (Type or print) <u>La Verne Constance Davis</u>		4. DATE OF DEATH <u>Oct 8 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-31</u>
9. AGE (In years last birthday) <u>30 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Tracy</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Wellman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Police Record</u>	
17. INFORMANT <u>Police Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombic hemorrhage</u> 981X DUE TO (b) <u>Bullet wound Throat</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Reputed shot by husband</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reputed shot by husband</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:10 PM 10-8-61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschatt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-8-61</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '61</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

law require.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11549

CERTIFICATE OF DEATH

11534

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 39 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase 15 d. STREET ADDRESS 14 Grafton Street	
3. NAME OF DECEASED (Type or print) RUTH JACOBS DAVIS		4. DATE OF DEATH Month October Day 16 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1910	
9. AGE (in years last birthday) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 15 Hours 15 Min.	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Mary O. Shipley		14. MOTHER'S MAIDEN NAME Mary O. Shipley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Widespread metastatic disease from bronchogenic carcinoma DUE TO c) 15 months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 3 months	
21. I certify that (this hospital) attended the deceased from September 7, 1961 to October 16, 1961 that (we) last saw the deceased alive on Oct. 16, 1961 and that death occurred at 1:45 PM from the causes and on the date stated above.		22. SIGNATURE J. David Heywood, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/20/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25. REC'D BY REGISTRAR OCT 18 '61	
25a. ADDRESS 2901 14th St. N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO SPIRITUAL OR ATTENDING PHYSICIAN: This death certificate is to be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE
HEALTH DEPT.

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11535											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>						c. LENGTH OF STAY IN 1b <u>80A.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Parklawn Rd.</u>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
3. NAME OF DECEASED (Type or print) <u>George Jay Deegan</u>						d. STREET ADDRESS <u>4715 Oakwood Rd. Randolph Hills</u>					
5. SEX <u>male</u>						4. DATE OF DEATH <u>Oct 1 1961</u>					
6. COLOR OR RACE <u>White</u>						7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>12-3-26</u>						9. AGE (In years last birthday) <u>34</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Project Analyst Navy Dept.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>new york</u>					
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>George J. Deegan</u>						14. MOTHER'S MAIDEN NAME <u>Gertrude Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WWII</u>						16. SOCIAL SECURITY NO. <u>Anna Marie Deegan - Item #2</u>					
17. INFORMANT <u>Anna Marie Deegan</u>						Address <u>Item #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO <u>Shot gun wound thru heart</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self inflicted shot gun wound thru heart</u>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>											
20c. TIME OF INJURY Month, Day, Year <u>10-1 1961</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parklawn Rd</u>											
20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>MD</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.											
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>10-4-61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>											
22d. LOCATION (City, town, or country) <u>MD</u> (State) <u></u>											
23. FUNERAL DIRECTOR <u>Thomas B. Hulan</u> ADDRESS <u>3831 G Ave</u>											
24a. REC'D BY REGISTRAR <u>OCT 6 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hulan</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Dr. Brochart notified

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
11551		11538	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	a. STATE	b. COUNTY
Montgomery	MARYLAND	Maryland	Prince Georges
c. LENGTH OF STAY IN 1b	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS
Takoma Park	D.O.A.	Takoma Park,	7900 Cole Avenue,
Washington Sanitarium and Hospital			
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	5. SEX	6. COLOR OR RACE
Delia	Dennean	Female	White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years if under 1 year, if under 24 hrs., last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Housewife	New York City, N.Y.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Joseph McCoy	Margaret Ward	no	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ...			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Oct. 1961, that (I) (we) last saw the deceased alive on Oct 5 1961, and that death occurred 2:28M, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Louis M. Jimal		10-5-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Louis M. Jimal M. D.		4008 Bladensburg Road, Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		10/7/1961	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Ft Lincoln		Bladensburg, Md	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home		DATE OCT 9 '61	
Washington 2, D.C.		Charles S. Thomas	

3-2

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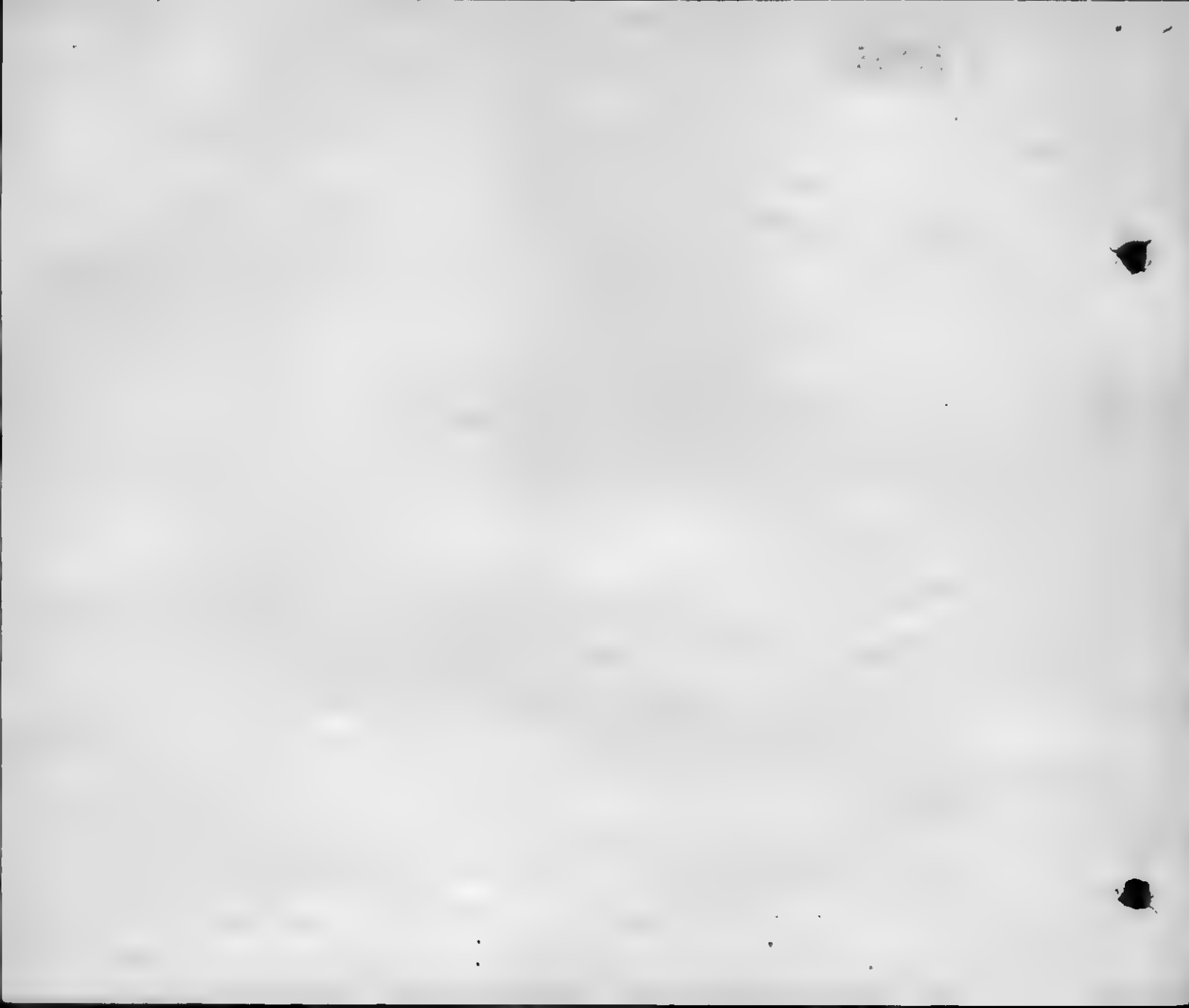
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11557

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DoA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> d. STREET ADDRESS <u>9915 Big Rock Rd</u>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joan Marie DeLoST</u>		4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1961</u>		10. AGE (In years last birthday) <u>11-18-59</u> IF UNDER 1 YEAR: Months <u>10</u> Days <u>22</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Valmore DeLoST</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Workman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VIRAL (VICK-TIAL) PNEUMONIA</u> 492X DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschak</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschak</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-10-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	
22d. LOCATION (City, town, or country) <u>ARLINGTON, VIRGINIA</u>		22e. (State) <u>VA</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR <u>F. J. Collins</u>		ADDRESS <u>WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 13 '61</u>		24c. REGISTRAR'S SIGNATURE	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11553

CERTIFICATE OF DEATH

11538

1. PLACE OF DEATH BELMONT NURSING HOME

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

SILVER SPRING MD 5 MO.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

BELMONT NURSING HOME

3. NAME OF DECEASED (Type or print)

ELLEN (NELLIE) DICKSON

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10-25-75

4. DATE OF DEATH

OCT 6 1961

9. AGE (in years last birthday)

85 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

NAVE

U.S.A.

NEW YORK CITY

USA

13. FATHER'S NAME

14. MOTHER'S M.A.D.N. NAME

RICHARD OWENS

MC GELLYN - ANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

NONE

A. Mc. Donnell

17220 COLESVILLE RD S.S.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION (5 min)
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED White ☐ Non-White ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 7/9/61 to 10/6/61, that (I) (we) last saw the deceased alive on 10/6/61, and that death occurred at 6 PM, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

JOHN P. MARTIN M.D.

ATTENDING PHYSICIAN

MED. DIRECTOR ☐

STAFF PHYS. ☐

10/6/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF 10-9-61

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d. LOCATION (City, town or county)

Montgomery Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Francis J. Collins

ADDRESS

3821-14th St NW, Wash. D.C.

25a. REC'D BY REGISTRAR

OCT 9 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Evans

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1922

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Poolesville

c. LENGTH OF STAY IN

PO

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Id R-107 Poolesville

3. NAME OF DECEASED (Type or print)

Alfred Carroll Dorsey

5. SEX

male

6. COLOR OR RACE

Cal.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-30-1912

4. DATE OF DEATH

Oct 9 1961

9. AGE (in years last birthday)

49 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Frank Dorsey

14. MOTHER'S MAIDEN NAME

Martha Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Hospital record:

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

825X DUE TO

Exsanguination

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Rupture of heart

(c)

Crushed Chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Sudden

Sudden

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Passenger in auto involved in accident

20c. TIME OF INJURY Month, Day, Year

1:39 a.m. 10-9 1961

20d. INJURY OCCURRED While ☐ el work ☒ el work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Id R-107

20f. (City or town)

Poolesville Montg

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

10-9-61

EXAMINER'S NAME (Type)

FRANK J. Broschart

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/12/61

22c. NAME OF CEMETERY OR CREMATORY

Warren Chapel Cemetery, Martinsburg, Md.

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

Robert L. Sworden

ADDRESS

Rockville, Md.

24a. REC'D BY REGISTRAR

OCT 17 '61

24b. REGISTRAR'S SIGNATURE

Charles L. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

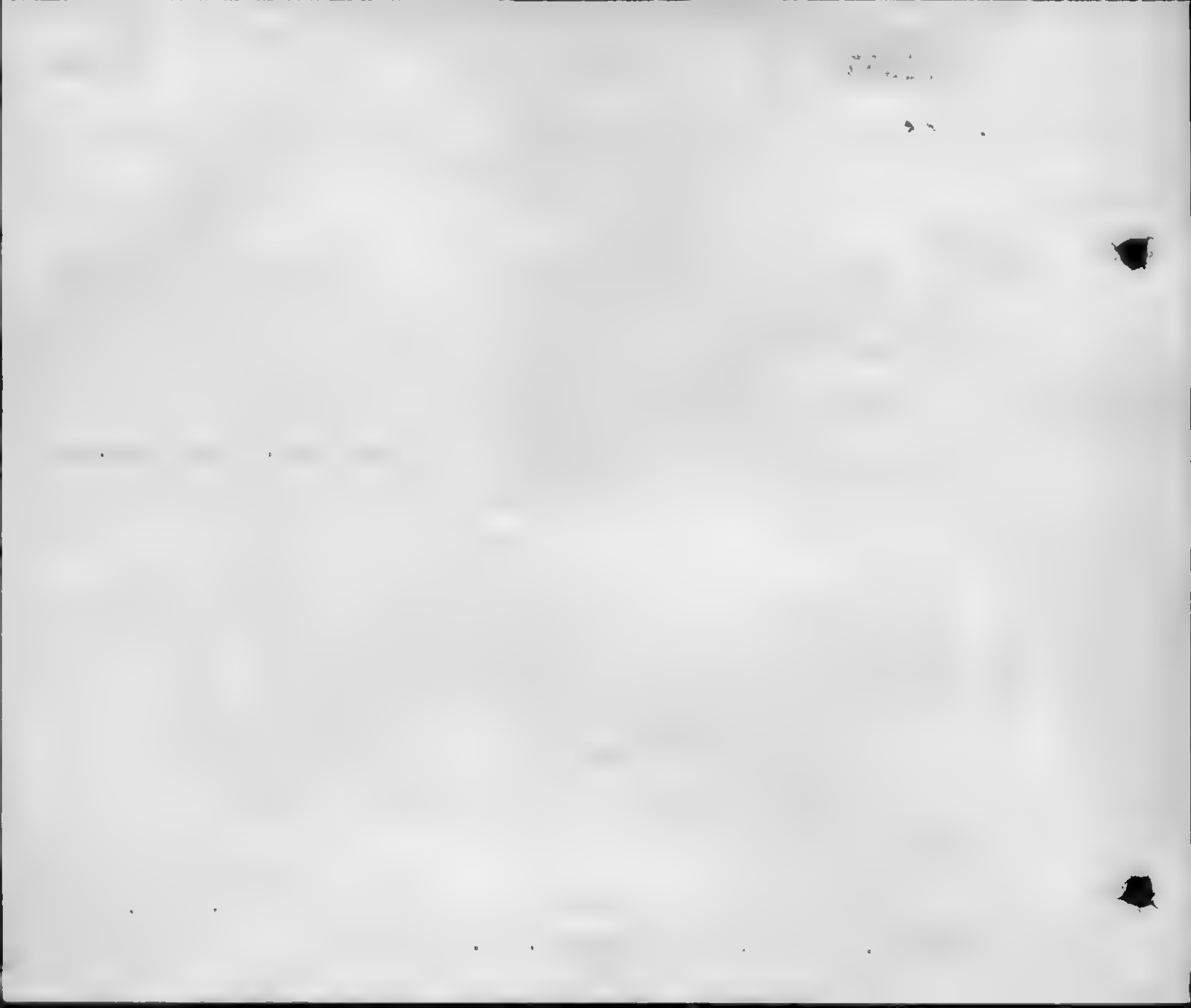
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11555

CERTIFICATE OF DEATH

11540

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Germantown Rural</u>	
c. LENGTH OF STAY IN IL <u>30 yrs</u>		d. STREET ADDRESS <u>/</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Rebecca Dunn</u>		4. DATE OF DEATH Month Day Year <u>Oct 20th 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1st 1879</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8 19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mc</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Leonard Barth</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Pruesel Gelf.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Charles Howard Dunn, Germantown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>1 year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Oct 19</u> , 1961, that (I) (we) last saw the deceased alive on <u>Oct 16</u> , 1961, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Vernon S. Masters</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Germantown Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-21-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Noelsville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Noelsville. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		25a. REC'D BY REGISTRAR <u>Oct 24 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert S. Hume</u>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11556

CERTIFICATE OF DEATH

11541

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4319 Altam Pl.,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George G. Duvall</u>		4. DATE OF DEATH Month Day Year <u>10 2 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/17/78</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. BIRTHPLACE (County & State or foreign country) <u>Woodward & Loth Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Perry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Percy D. Duvall-Son-Same 2d</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> (b) <u>Arteriosclerotic Heart Disease.</u> (c) <u>Prostatic Cancer with Metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>Arthritis Severe Right Hip.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 year</u> <u>34 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>Washington</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>10/2</u> , 19 <u>61</u> , and that death occurred at <u>8:20</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>P. P. Andrews</u>		22b. DATE SIGNED <u>10-2-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS</u>		22d. ADDRESS <u>4801 FESSENDEN ST. N.W. WASHINGTON D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2025

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give illegals 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11557

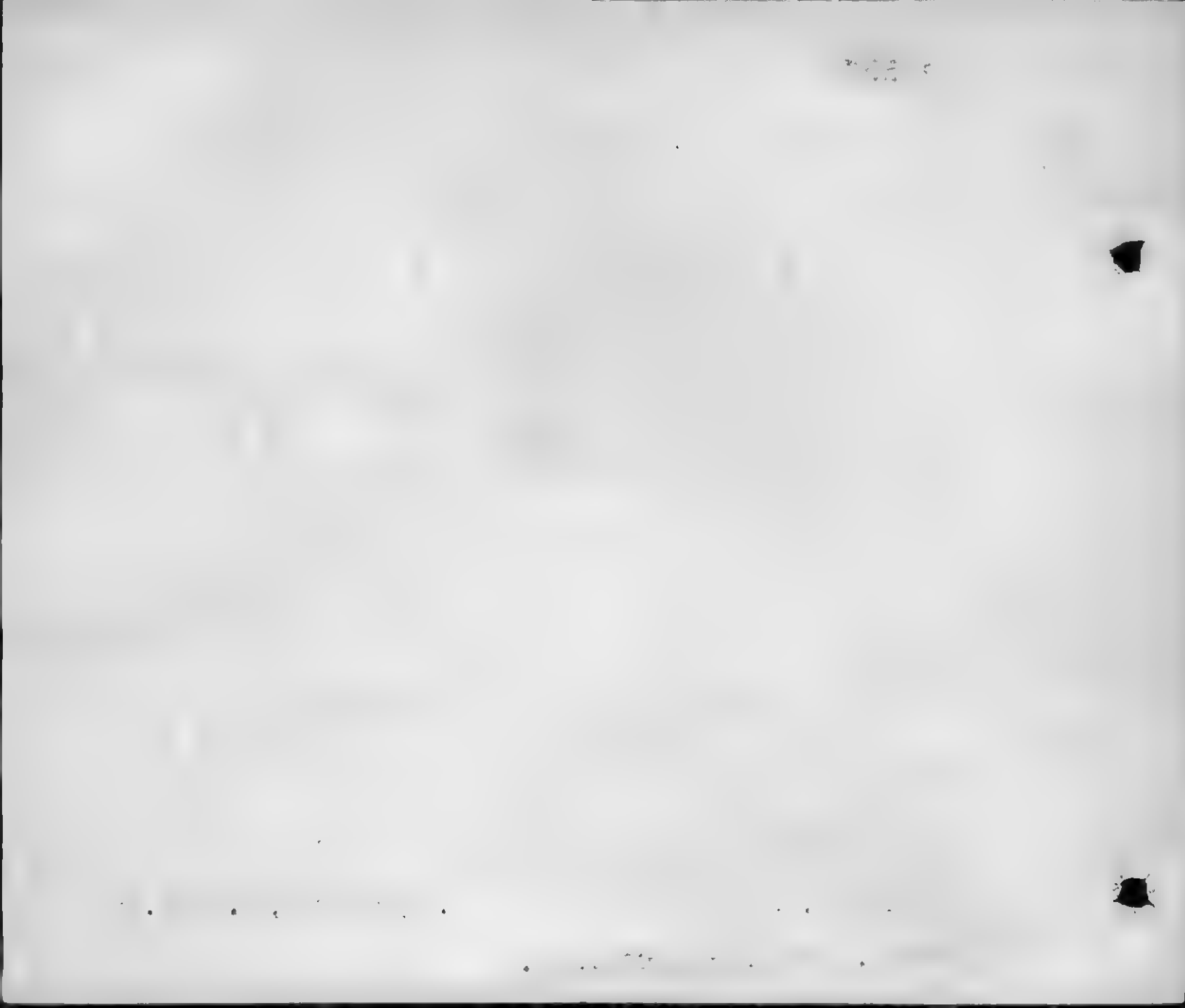
11542

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>2 1/2 hrs.</u>				d. STREET ADDRESS <u>1 Box 93</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Othe Early</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1932</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		10. UNDER 1 YEAR Months <u>2</u> Days <u>29</u>		11. UNDER 24 HRS. Hours <u>29</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver, MILK Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Glen Early</u>				14. MOTHER'S NAME <u>Anna Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-30-8646</u>			
17. INFORMANT <u>Madeline Early</u>				Address <u>As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Berry aneurysm at middle cerebral artery</u> DUE TO (c) <u>7 hr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				10-31-61			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>Burial</u>		<u>Nov. 2, 1961</u>		<u>Harmony</u>		<u>Nr. Myersville, Md. Fred. Co</u>	
23. FUNERAL DIRECTOR <u>Paul F. Bittle</u>				24a. REC'D BY REGISTRAR <u>NOV 2 '61</u>			
ADDRESS <u>Myersville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>James S. Pinner</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11558

CERTIFICATE OF DEATH

11543

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>2819 Key Boulevard</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH <u>October 6 1961</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian Ruth Edwards</u>		4. DATE OF DEATH <u>October 6 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/> B. DATE OF BIRTH <u>March 2, 1896</u>		9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS.) <u>65</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting Examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Powers</u>		14. MOTHER'S MAIDEN NAME <u>Rose Vermillion</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
204-1 } DUE TO		Chronic myelogenous leukemia	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>Sept. 11 1961</u> to <u>October 6 1961</u> , that <u>Dr.</u> (we) last saw the deceased alive on <u>October 6 1961</u> , and that death occurred at <u>7:11 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick H. Welland, M.D.</u>		22b. DATE SIGNED <u>10/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick H. Welland, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Benge</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 13 '61</u>	

8211

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11544

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY in 1b

4 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

1104 Dennis Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

md

b. COUNTY

montg

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

1104 Dennis Ave

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Joseph Carl Eggleston

4. DATE OF DEATH

Oct 25 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

6-28-1906

9. AGE (In years last birthday)

55 yrs

10. UNDER 1 YEAR

Months *0* Days *0*

11. UNDER 24 HRS.

Hours *0* Min. *0*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auto machine repair - Self-employed

10b. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Alexander Eggleston

14. MOTHER'S MAIDEN NAME

Virginia C. Hepler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

217-09-5374

17. INFORMANT

Winona Eggleston (wife) Item 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral hemorrhage & laceration

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DU TO

Shot gun wound

DU TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

malignant brain tumor

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Self inflicted shot gun wound

20c. TIME OF INJURY

Month, Day, Year

8:45 p.m. 10-25-1961

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

Home

20f. (City or town)

Silver Spring

(County)

Montg

(State)

md

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

10-25-61

EXAMINER'S NAME (Type)

FRANK J. BROSCART

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/28/61

22c. NAME OF CEMETERY OR CREMATORY

Cedarwood Cemetery

22d. LOCATION (City, town, or country)

Shennandoah Co. Virginia

(State)

23. FUNERAL DIRECTOR

*Raymond A. Ziska 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland*

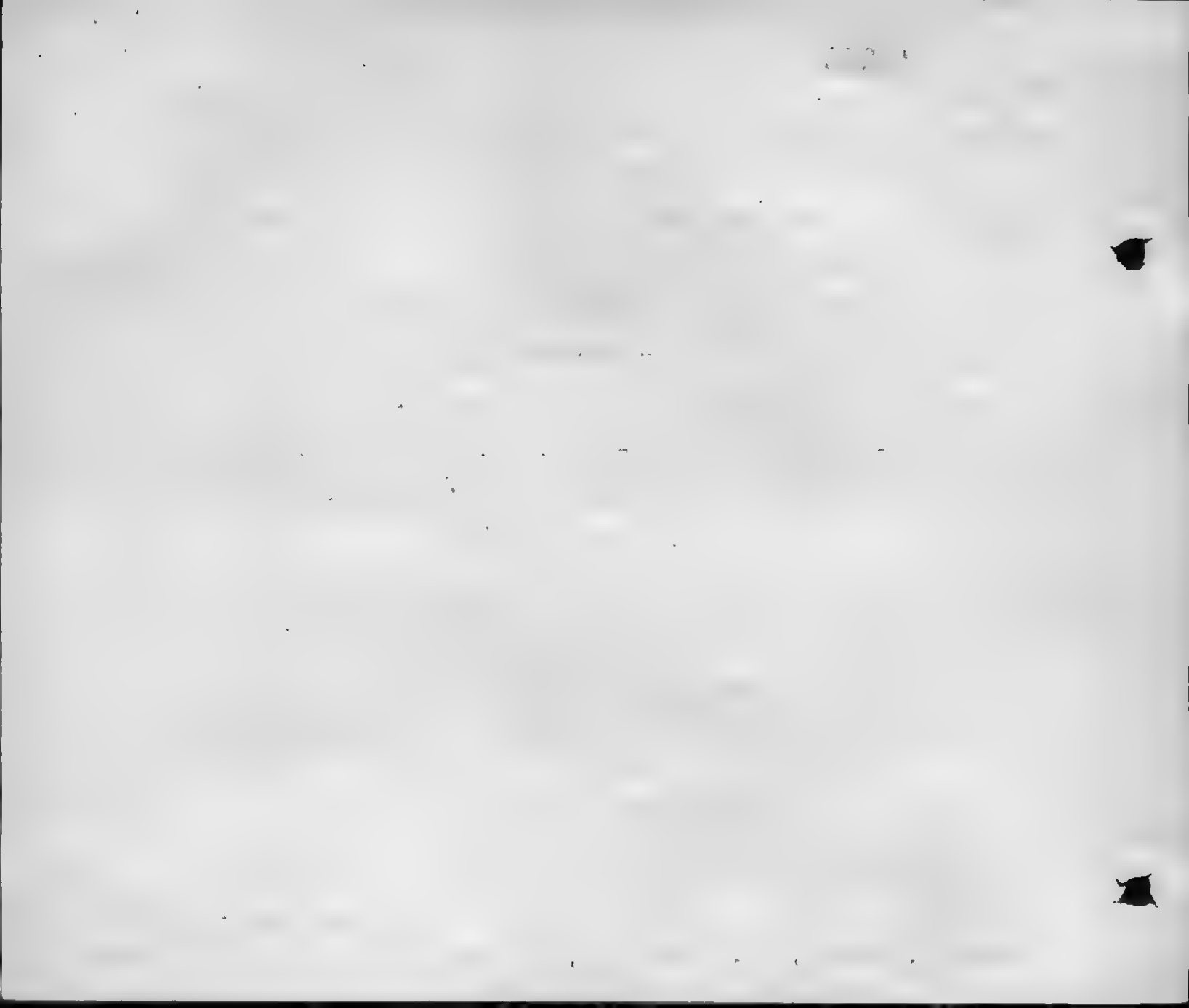
24a. REC'D BY REGISTRAR

OCT 27 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film C297 10/23/61 mh

11545

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>50 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5108 Wilson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Frank Engert</u>		4. DATE OF DEATH <u>10 16 1961</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-4-1910</u>		9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver School bus</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>		11. BIRTHPLACE (State or foreign country) <u>UNK Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Ruptured esophageal Varices</u> DUE TO (c) <u>Cirrhosis of Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNK</u>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broscham</u> M.D.		DATE SIGNED <u>10-17-61</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broscham</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 19. 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	
22d. LOCATION (City, town, or country) <u>Wheaton, MD</u>		22e. REC'D BY REGISTRAR <u>10-17-61</u>		22f. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11561

11548

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cherry Chase

c. LENGTH OF STAY IN 1b

4 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4008 Laird Place

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cherry Chase

d. STREET ADDRESS

14008 Laird Place

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Engine

First

Middle

Fallon

4. DATE OF DEATH

Oct

Month

Day

Year

1961

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-17-1908

9. AGE (In years last birthday)

53 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Civil Engineer

10b. KIND OF BUSINESS OR INDUSTRY

Engineering

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF WHAT COUNTRY?

41-8 C

13. FATHER'S NAME

Leo H. Fallon

14. MOTHER'S MAIDEN NAME

Marguerite Barnette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes WW 2

16. SOCIAL SECURITY NO.

577-46-3999

17. INFORMANT

Cecily Fallon (wife) Item 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

sudden

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

SIGNATURE

Frank J. Broschart

M.D.

EXAMINER'S NAME (Type)

FRANK J. Broschart

Address (Street, city, town, or county)

10-27-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/31/61

22c. NAME OF CEMETERY OR CREMATORY

Arlington Cemetery

22d. LOCATION (City, town, or country)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR

ADDRESS

Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR

DATE OCT 31 '61

24b. REGISTRAR'S SIGNATURE

Cynthia L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

tems 18&21 Film 299 17-3-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11547

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY in 1b 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8412 Ramsey Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD b. COUNTY Montg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 8412 Ramsey Ave

3. NAME OF DECEASED (Type or print) Doris Overton Fernandez
4. DATE OF DEATH Oct 14 1961
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-25-07
9. AGE (In years last birthday) 54 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY N.C 11. BIRTHPLACE (State or foreign country) N.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown Overton 14. MOTHER'S MAIDEN NAME Unknown Spruill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 578-26-9210 17. INFORMANT Jack Mettler (son)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Barbiturate poisoning
871.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interval between onset and death
DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
ACTUAL SIGNATURE Frank J. Broschert M.D. DATE SIGNED 10-15-61
EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/17/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Montgomery County, Maryland
23. FUNERAL DIRECTOR Warner E. Pumfrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland 24a. REC'D BY REGISTRAR OCT 17 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11563

11548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>41 hrs</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u> d. STREET ADDRESS <u>1 Oakcrest Trailer Ct</u>	
3. NAME OF DECEASED (Type or print) <u>Suburban Hospital</u> First Middle <u>Baby</u> <u>Neil</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF DEATH <u>Oct. 7, 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 9. AGE (in years last birthday) <u>41</u> IF UNDER 1 YEAR: Months <u>41</u> Days <u>9</u> Year <u>1961</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sterven L. Fields</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Hosp. Record.</u>		14. MOTHER'S MAIDEN NAME <u>ILM Payne</u> Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory FAILURE</u> Conditions, if any, which gave rise to immediate cause (b) <u>Multiple Cerebral petechial Hemorrhage</u> (c), stating the underlying cause last. <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> 20c. TIME OF INJURY Month, Day, Year <u>10/7/61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/7/61</u> , to <u>10/19/61</u> , that (I) (we) last saw the deceased alive on <u>10/19/61</u> , and that death occurred <u>10/19/61</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Paulman</u> M.D.		22b. DATE SIGNED <u>10/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>-</u>		22d. ADDRESS <u>-</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>10/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>BETHESDA, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER, ADMIN.</u> <u>(PER F.B.)</u>		25a. REC'D BY REGISTRAR <u>OCT 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>OLD GEORGETOWN RD.</u> <u>BETHESDA, MD.</u>	

74211XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



11-18-61 film 300

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11564

11549

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If inst tution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

8907 Kensington Pkway

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

KATHARINE

FIGUEROA

4. DATE OF DEATH

October 29 1961

5. SEX

Female White

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH

February 23, 1927

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Typist

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov.

11. BIRTHPLACE (State or foreign country)

SANTURCE, PUERTO RICO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALCIDES FIGUEROA

14. MOTHER'S MAIDEN NAME

KATHARINE SHEIBLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT (AUNT)

Address

SARA FIGUEROA

AS ABOVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Chronic barbiturate poisoning

871.2 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Reported that she had been taking barbiturates regularly during past year. She was driving auto 10/27/61 when she sideswiped two cars. She was not injured. Taken to hospital under influence of barbiturates.

20c. TIME OF INJURY

Hour a.m. - p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschant

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. Broschant

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

10-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

Nov. 2 1961

22c. NAME OF CEMETERY OR CREMATORY

GATE OF HEAVEN Cem.

22d. LOCATION (City, town, or county)

Shelton, Maryland

(State)

23. FUNERAL DIRECTOR

H. Don. DeVol-2224-Wash. D.C.

ADDRESS

Wash. D.C.

24b. REC'D BY REGISTRAR

NOV 3 '61

24c. REGISTRAR'S SIGNATURE

Arthur L. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

(M)

(I)

AP



CERTIFICATE OF DEATH

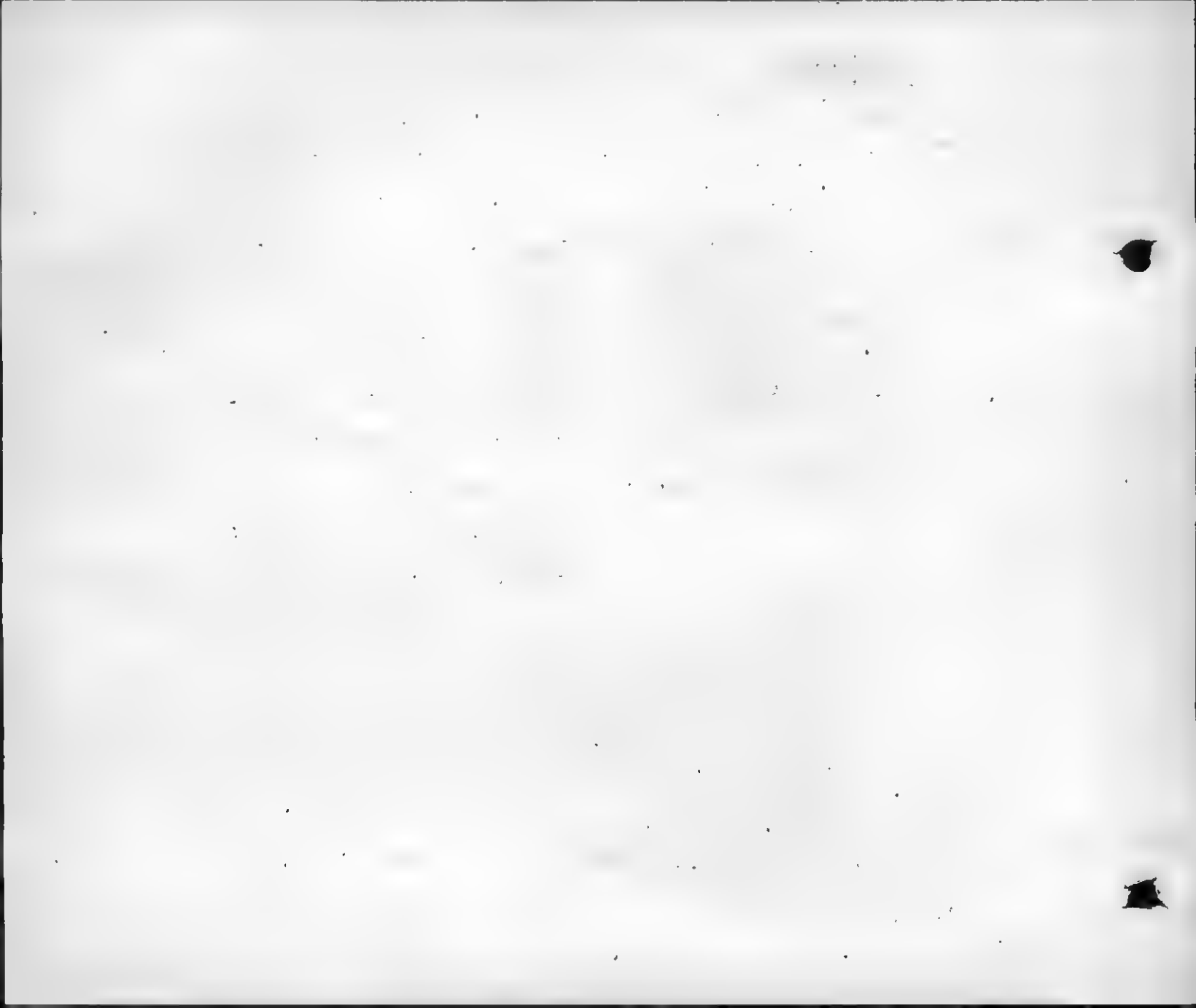
Reg. Dist. No. 11550

11563

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 9 MOS		d. STREET ADDRESS 2424 ROSS RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2424 ROSS RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle FISCHGRUND Last FISCHGRUND		4. DATE OF DEATH Month OCT Day 19 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 19, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 29 Hours 19 Min.	11. IF UNDER 24 HRS. Months 7 Days 29 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT SASSERATH		14. MOTHER'S MAIDEN NAME ROSA ROSENZWEIG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO —	
17. INFORMANT BERNARD FISCHGRUND		Address 2303 E.W. HIGHWAY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEART DISEASE (c) HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 50 , to OCT 19 , 19 61 , that I last saw the deceased alive on OCT 19 , 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar		ADDRESS (Street, city or town, state) 4637 EASTERN AVE WASHINGTON 18, DC	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		DATE SIGNED OCT 19, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-20-61	
22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Sanyansky		ADDRESS Dons - 3501-14th NW	
24a. REC'D BY REGISTRAR OCT 23 '61		24b. REGISTRAR'S SIGNATURE C. R. H. S. Kama	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

11551

11566

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8405-SPENCER COURT		d. STREET ADDRESS 8405 SPENCER COURT	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle FISHER Last FISHER		4. DATE OF DEATH Month OCTOBER Day 12 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1897
9. AGE (In years lost birthday) 64 yrs		IF UNDER 1 YEAR: Months 6 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY LATVIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WOLF FISHER		14. MOTHER'S MAIDEN NAME HANNAH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 578-482-793	
17. INFORMANT HERMAN FISHER		Address 8153 E. BEACH DR. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Over 2 years			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1960 to Oct 5, 1961 , that I last saw the deceased alive on Oct 5, 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Warren D. Brill, M.D.		M.D. 2601-16th Street, N.W.	
PHYSICIAN'S NAME (Type) Warren D. Brill, M.D.		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10-13-61	KING DAVID MEMORIAL GARDEN	FALLS CHURCH, VA.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Langauky + Bros		24a. REC'D BY REGISTRAR OCT 16 '61	24b. REGISTRAR'S SIGNATURE Charles E. Fenn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 Film 310 4-2-61

11567

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11552

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN b 42 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL) Silver Spring / Easton
d. STREET ADDRESS 9293 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last Fleck

4. DATE OF DEATH
Month Oct Day 1 Year 1961

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sept. 30 1961

9. AGE (In years last birthday)
IF UNDER 1 YEAR: Months 7 Days 16
IF UNDER 24 HRS.: Hours 16 Mins. 16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Judith Fleck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE
754.5 DUE TO Congenital Heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1961 to Oct. 1, 1961, that (I) (we) last saw the deceased alive on Oct. 1, 1961, and that death occurred at 10:30 PM, from the causes and on the date stated above.

22a. SIGNATURE Robert P. Warthen M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Robert P. Warthen

22d. ADDRESS 3716 Howard Ave Kensington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

23b. DATE THEREOF Oct. 3, 1961

23c. NAME OF CEMETERY OR CREMATORY Fair Lincoln Crematory

23d. LOCATION (City, town or county) Prince Geo. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters ADDRESS 254 Carroll St. N.W. D.C.

REC'D BY REGISTRAR Arthur S. Kinne

DATE OCT 4 '61

25b. REGISTRAR'S SIGNATURE

VR A15 (4)
15M 9/60



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FOR STATE
HEALTH DEPT.

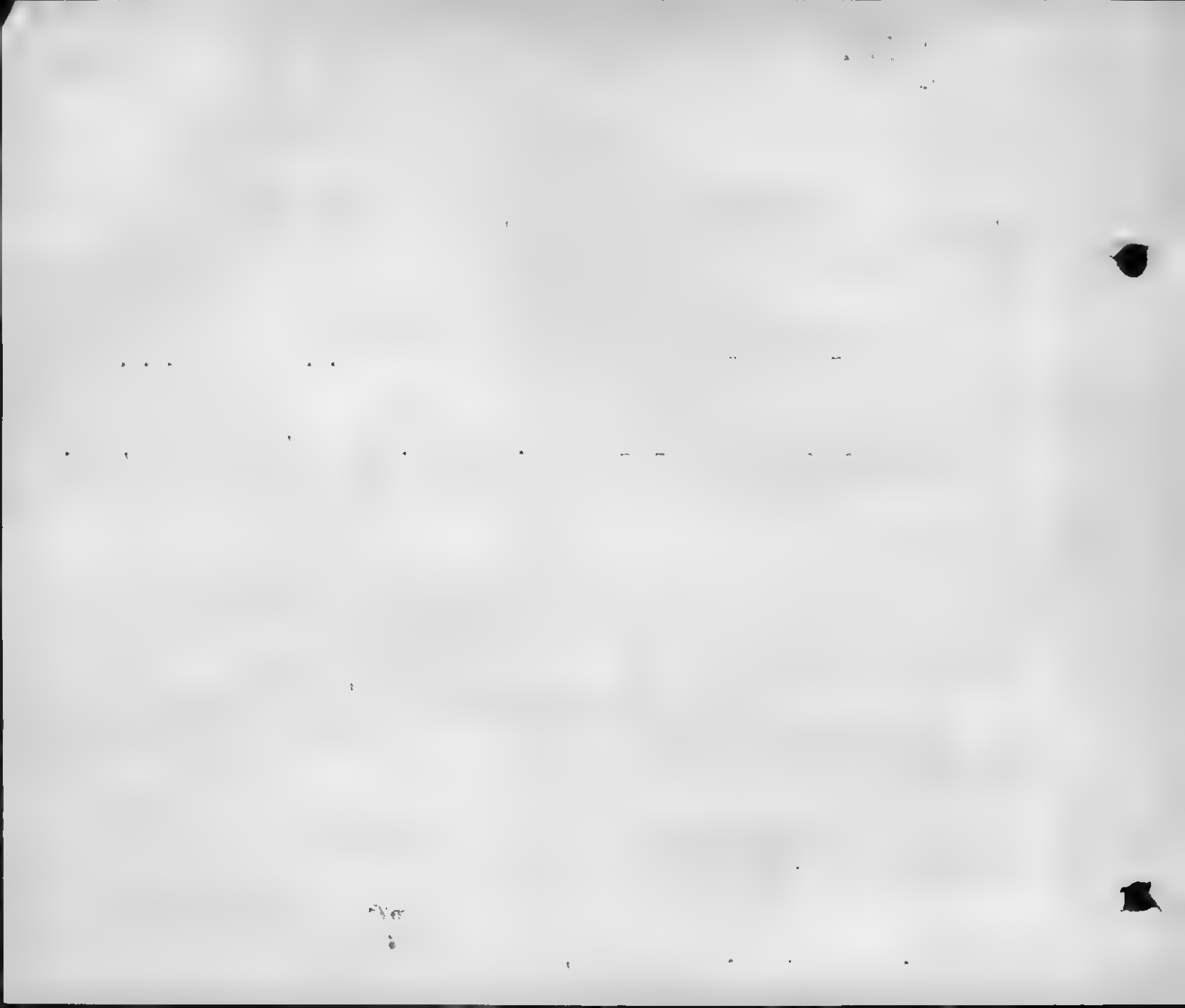
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

11568
11553
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 19 years		2. USUAL RESIDENCE (Where deceased lived, if not full-time; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mansion Drive		e. STREET ADDRESS Mansion Drive		f. DATE OF DEATH October 5 19 61		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Katie Mae Flester		4. SEX Female		5. COLOR OR RACE white		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		7. DATE OF BIRTH October 28, 1893		8. AGE (in years last birthday) 67 yrs.	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress - Retired-Mayflower Hotel		10. KIND OF BUSINESS OR INDUSTRY Washington D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Lucian Lovelace		14. MOTHER'S MAIDEN NAME Ida Sidnor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 577-03-0613		17. INFORMANT Mrs. Edmund P. Hammett		18. ADDRESS 1,007 North Mansion Drive Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/61		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or country) Montgomery County, Maryland	
23. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc.		24a. REC'D BY REGISTRAR OCT 9 '61		24b. REGISTRAR'S SIGNATURE Arthur L. House		25. CHIEF MEDICAL EXAMINER Frank J. Broschart		26. ASSISTANT MEDICAL EXAMINER		27. DEPUTY MEDICAL EXAMINER 10-5-61	

MEDICAL CERTIFICATION



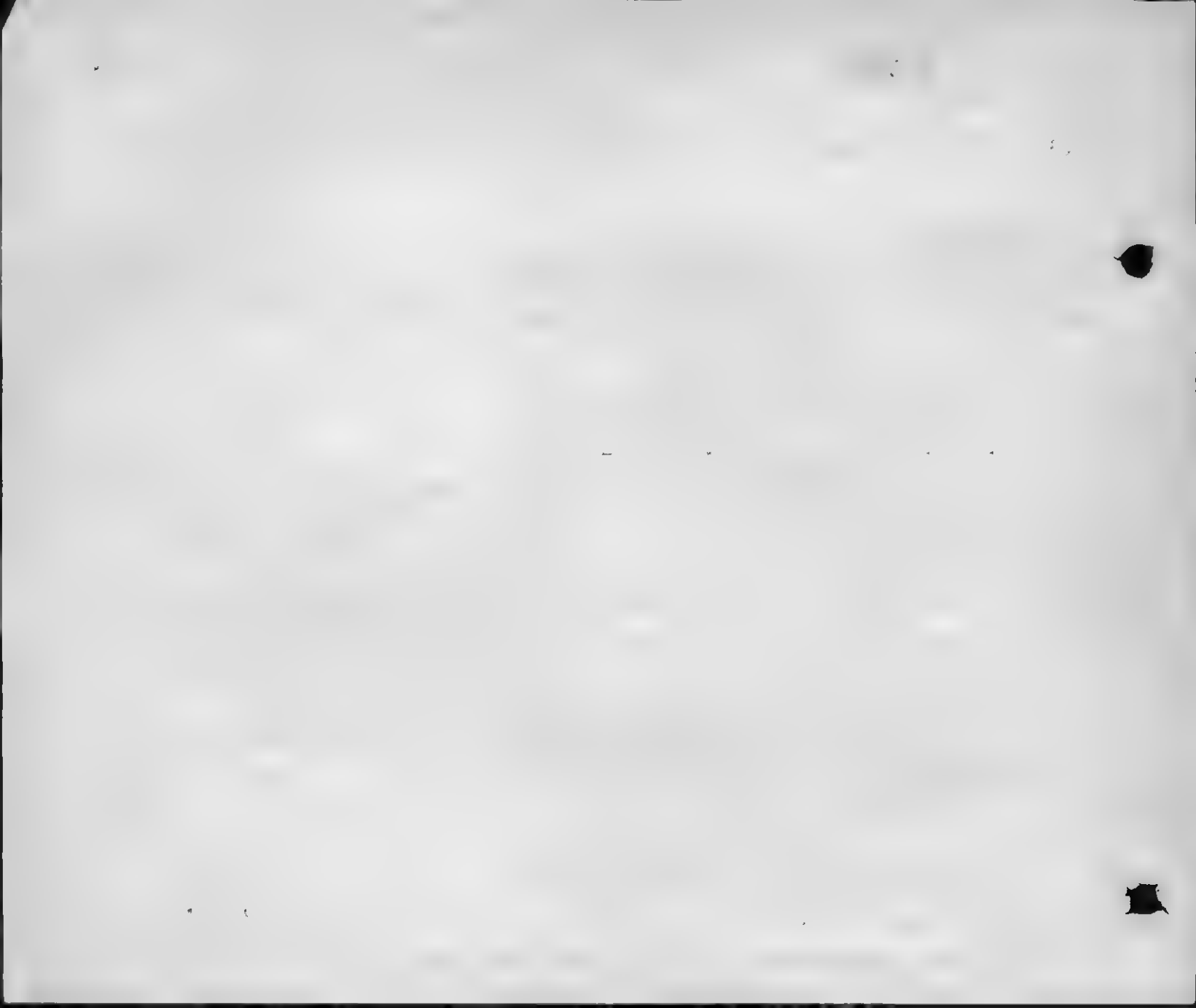
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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

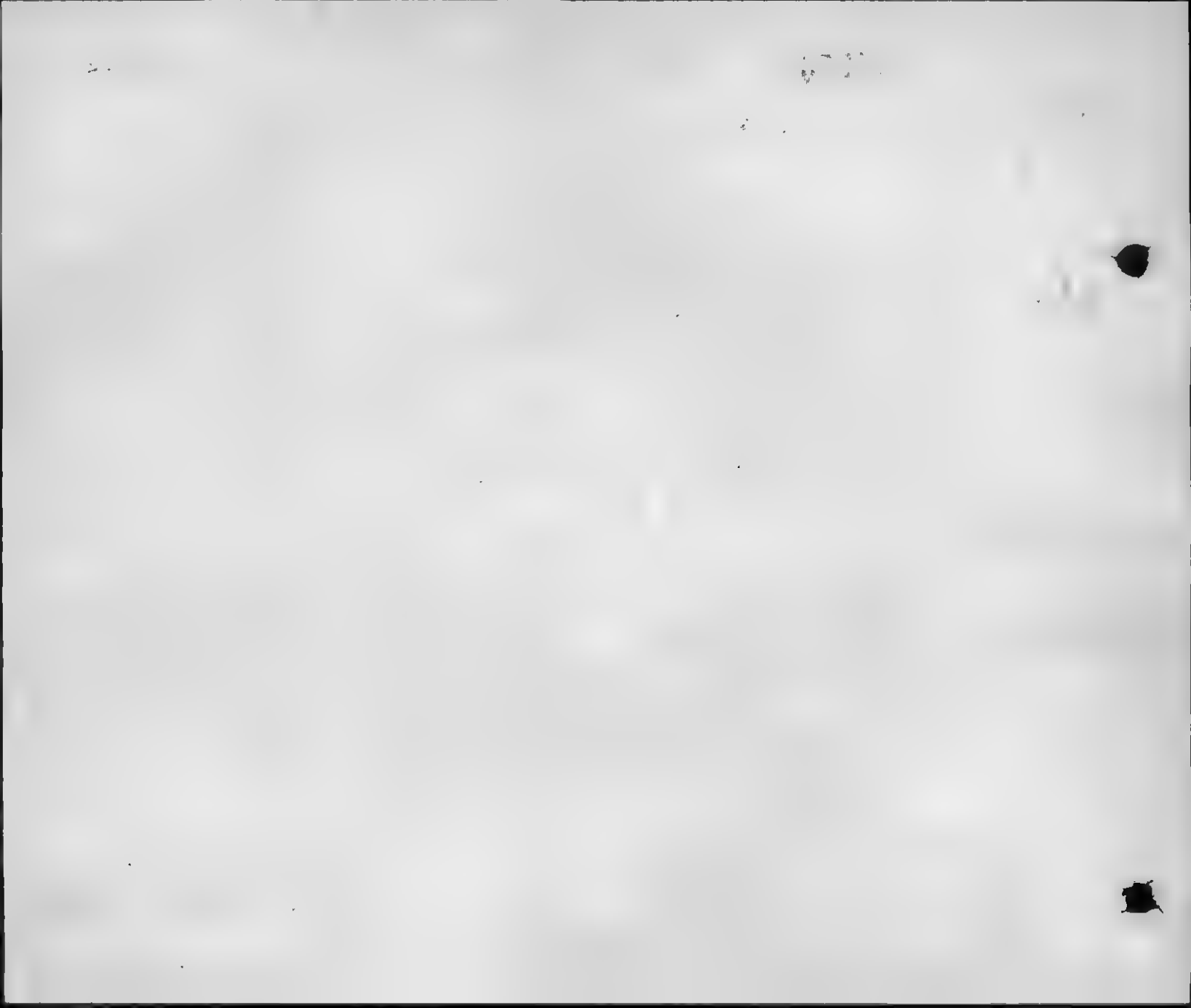
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11554

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u> c. LENGTH OF STAY IN 1b <u>14 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5802 Augusta Lane - Wash 16</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u> d. STREET ADDRESS <u>5802 Augusta Lane - Wash 16</u>	
3. NAME OF DECEASED (Type or print) <u>Laura Elizabeth Foller</u> 4. DATE OF DEATH <u>Oct 11 1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>4-30-1855</u> 8. AGE (in years last birthday) <u>106</u> yrs.	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u> 11. BIRTHPLACE (State or foreign country) <u>Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Foller</u> 14. MOTHER'S MAIDEN NAME <u>- - -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>- - -</u> 17. INFORMANT <u>Helen F. Beddick - Glen 2</u> Address <u>- - -</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of gastric contents</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Adenocarcinoma of breast with metastases</u> link (c) <u>link</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- - -</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - -</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - -</u> 20f. (City or town) (County) (State) <u>- - -</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Brosch</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		DATE SIGNED <u>10-11-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>10-13-1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 22d. LOCATION (City, town, or country) (State) <u>Suitland, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 16 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
23. FUNERAL DIRECTOR <u>Joseph Gaudin & Son, Inc. 1756 B Ave NW</u>			



DATE OCT 19 '61

Clifford P. House



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

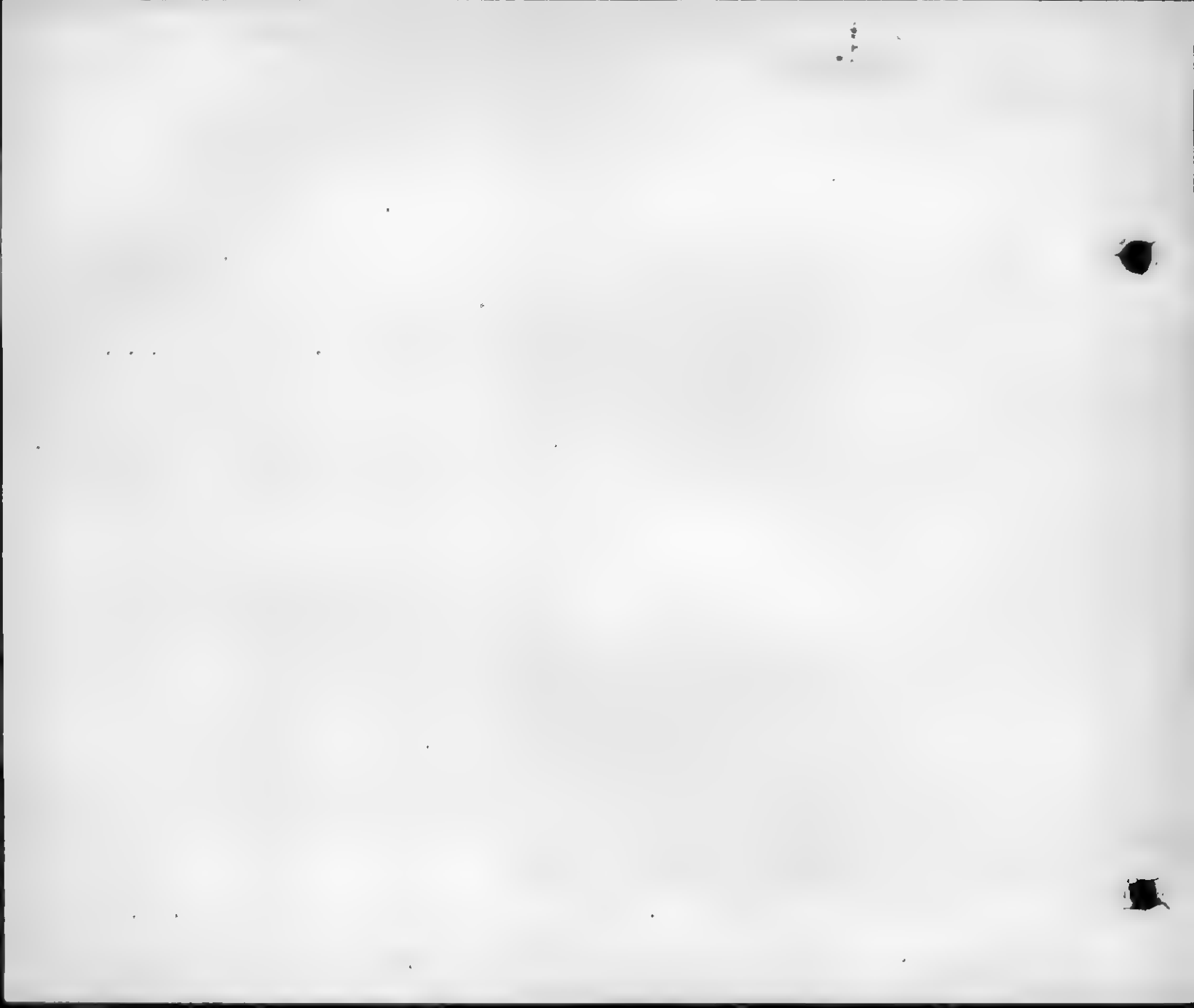
VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11571

11556

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5415 Conn. Ave. Apt. 423	
3. NAME OF DECEASED (Type or print) First ROCE Middle RIZZO Last GAUZZA		4. DATE OF DEATH Month Oct. Day 27 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1879
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rizzo		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roy Gauzza (son)		Address 10907 Jollyway Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 333 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 17 days DUE TO (c) 17 days		INTERVAL BETWEEN ONSET AND DEATH 17 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to October 27, 1961, that (I) (we) last saw the deceased alive on October 26, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE James M. Haffner		22b. DATE SIGNED Oct 31 '61	
22c. PHYSICIAN'S NAME (Type) James M. Haffner		22d. ADDRESS 1756 Pa Ave NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 30 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Connelley		25a. REC'D BY REGISTRAR DATE OCT 31 '61	
25b. REGISTRAR'S SIGNATURE William S. Funn			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11572 CERTIFICATE OF DEATH 11557

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 73 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Florida b. COUNTY Hollywood c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3311 Southwest 36th Street d. STREET ADDRESS 3311 Southwest 36th Street	
3. NAME OF DECEASED (Type or print) Nancy Louise Gibson		4. DATE OF DEATH Month October Day 17 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1950	
9. AGE (In years, last birthday) 11 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
11. BIRTHPLACE (Country & State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth Gibson		14. MOTHER'S MAIDEN NAME Ruth Meager	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e): Septicemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Pancytopenia DUE TO (c) Bone Marrow aplasia, Acquired	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days 7 months 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 5, 1961 to October 17, 1961, that (I) (we) last saw the deceased alive on October 17, 1961, and that death occurred at 9:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Henderson EDWARD S. HENDERSON, M.D.		22b. DATE SIGNED 10/18/61	
22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/19/61	
23c. NAME OF CEMETERY OR CREMATORY W. Hollywood		23d. LOCATION (City, town or county) (State) Fla.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc		25a. REC'D BY REGISTRAR DATE OCT 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1934

21



1934

22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11573
11558
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>One day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8806 Georgia Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude May Goble</u>		4. DATE OF DEATH <u>October 10 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>July 25, 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silas Goble</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kolb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Washington Sanitarium and Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERGLYCEMIC ACIDOSIS AND COMA</u> DUE TO (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>FEW HOURS</u> <u>1 DAY</u> <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER, 1953</u> to <u>OCTOBER 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 10, 1961</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u>		22b. DATE SIGNED <u>OCTOBER 10 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7733 ARASKA AVENUE N.W. WASHINGTON 12 D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/13/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>OCT 13 '61</u>	
Warner E. Pumphrey, Inc. Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE <u>Cirley L. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

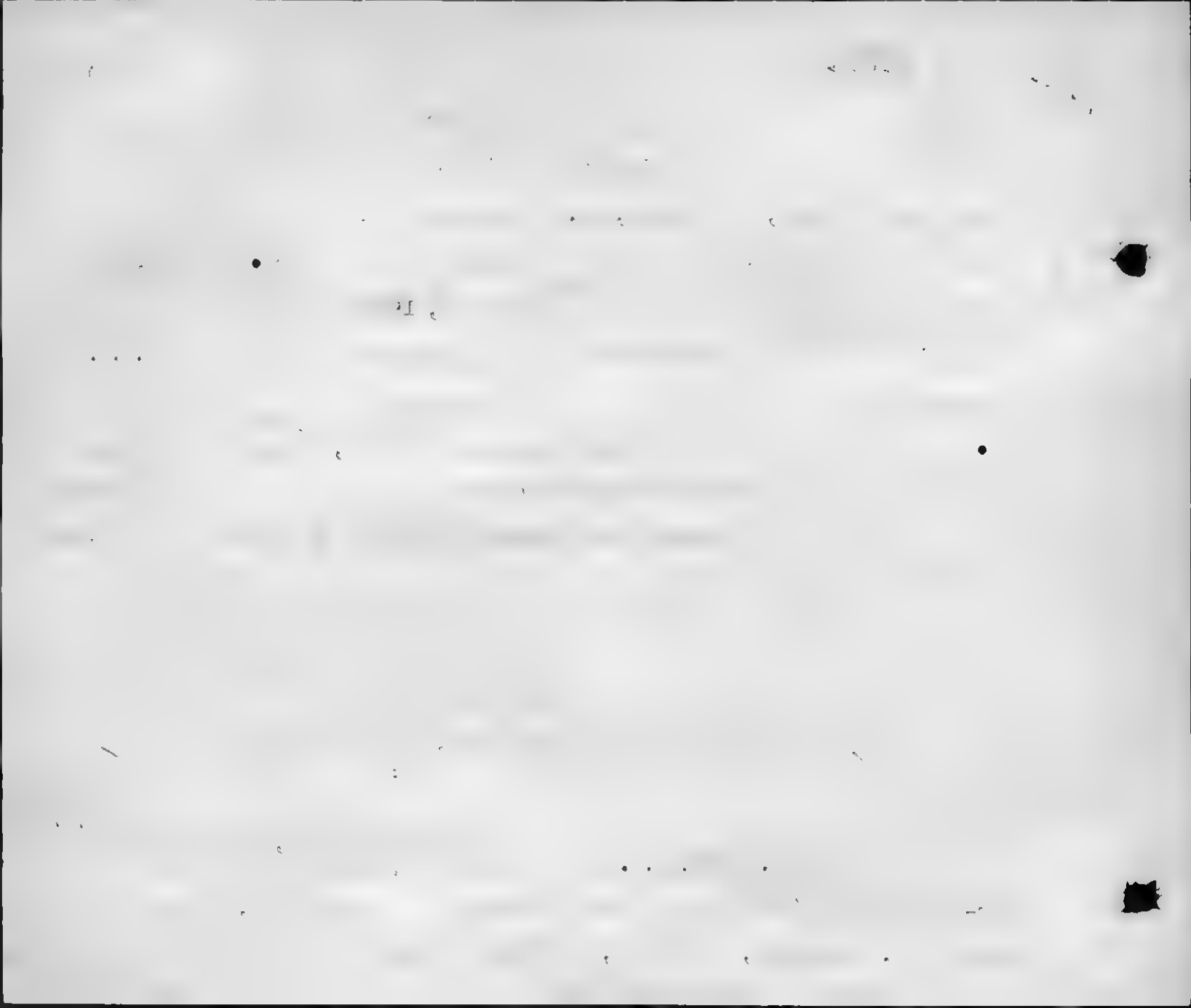
11574

11559

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Rich Hill	
c. LENGTH OF STAY in 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 320 Cedar Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			
3. NAME OF DECEASED (Type or print) Larry		4. DATE OF DEATH October 1, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 9, 1940	
9. AGE (in years, if UNDER 1 YEAR, last birthday)		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
11. BIRTHPLACE (City & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Gordon		14. MOTHER'S MAIDEN NAME Sue Denayer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unavailable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 3 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Congenital Heart Disease (Tetralogy of Fallot)		20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from September 20, 1961 to October 1, 1961, that (we) last saw the deceased alive on October 1, 1961, and that death occurred at 11:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Dean T. Mason		22b. DATE SIGNED 10/2/61	
22c. PHYSICIAN'S NAME (Type) DEAN T. MASON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 10/3/61	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Rich Hill, Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
6
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11575
11560
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>11) MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 40</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10106 GEORGIA AVE</u>		d. STREET ADDRESS <u>10106 GEORGIA AVE.</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>-</u> Last <u>GORIN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE-15-1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BARRY GORIN</u>		14. MOTHER'S MAIDEN NAME <u>LEAH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>578-46-528</u>	
17. INFORMANT <u>NORMAN GORIN</u> Address <u>1311-29 1st St. NW DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery disease</u> DUE TO (c) <u>Coronary artery disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> to <u>10/25</u> 19 <u>61</u> . That <u>we</u> last saw the deceased alive on <u>10/24</u> 19 <u>61</u> and that death occurred at <u>8:30</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>John J. Rheingold MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>		22d. ADDRESS <u>1301 18th St. NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>D.C. ROGGE CEM.</u>		23d. LOCATION (City, town, and county) (State) <u>Wash., DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Josephine Home</u>		ADDRESS <u>4217 9th St NW</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	
DATE <u>OCT 30 '61</u>			

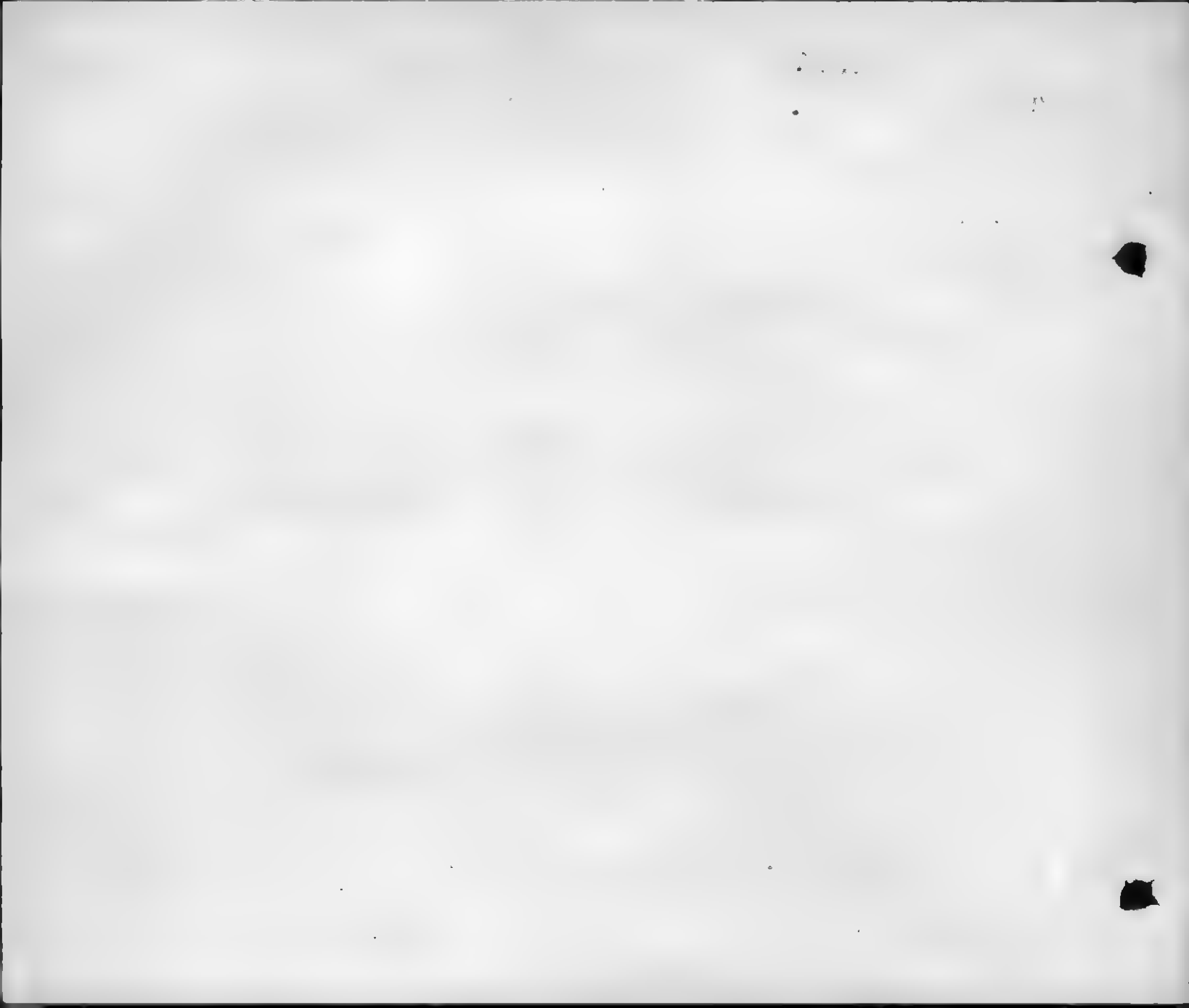


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
11576 CERTIFICATE OF DEATH 11561																			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania Md.														
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 16 days														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. STREET ADDRESS 205 Granville Drive														
3. NAME OF DECEASED (Type or print) Helen					4. DATE OF DEATH October 7 1961														
5. SEX Female					6. COLOR OR RACE Caucasian														
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH March 4, 1917														
9. AGE (In years last birthday) 44 yrs.					10. IF UNDER 24 HRS. Months Days Hours Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania														
11. BIRTHPLACE (County & State, or foreign country) USA					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Arthur Hugh Pidgeon					14. MOTHER'S MAIDEN NAME Helen / Kathryn Emma Lauffsford														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. 577 14 5465														
17. INFORMANT Richard D. Gottlieb					Same as #2 above														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Gastrointestinal Hemorrhage 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) - Cirrhosis, Liver Laënnec's 5810 (a), stating the underlying cause last. DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 7 days Years -																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that (a) (this hospital) attended the deceased from Sept 21, 1961 to Oct 7, 1961 that (b) (we) last saw the deceased alive on October 7, 1961, and that death occurred at 2:40 AM from the causes and on the date stated above.																			
22a. SIGNATURE Robert E. De Forest										22b. DATE SIGNED October 7, 1961									
22c. PHYSICIAN'S NAME (Type) Robert E. De Forest										22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 10 Oct 1961									
23c. NAME OF CEMETERY OR CREMATORY Arlington National										23d. LOCATION (City, town or county) (State) Arlington Va.									
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey										25a. REC'D BY REGISTRAR OCT 10 '61									
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes																			



DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

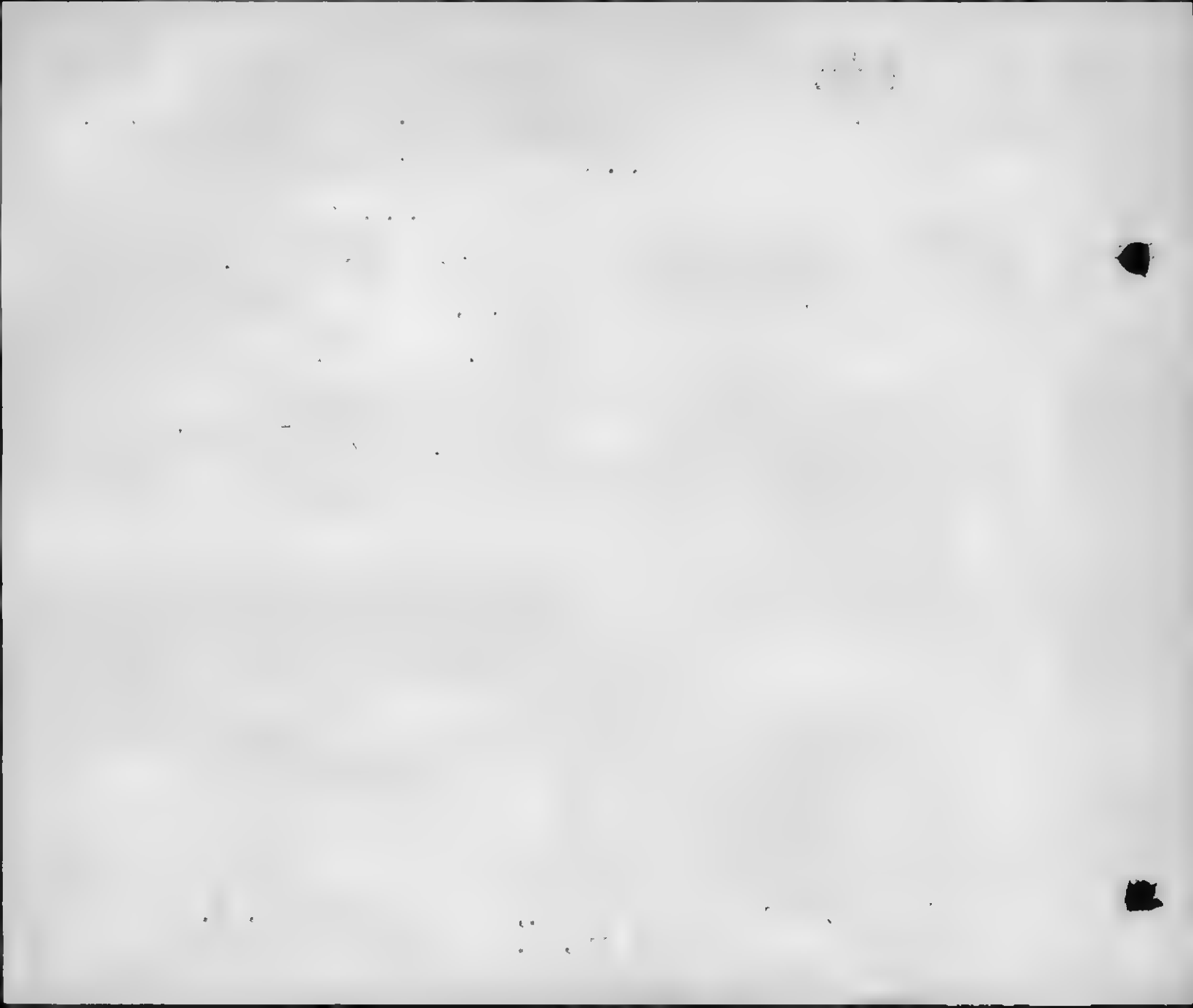
FOR STATE
HEALTH DEPT. **M**

12
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11577

11562

1. PLACE OF DEATH a. COUNTY Mont. Co.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Mont. Co.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS R.F.D. #3		3. NAME OF DECEASED (Type or print) Gloria Natalie Gray alias Cromwell		4. DATE OF DEATH Month: Oct. 14, 1961	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1926		9. AGE (in years last birthday) 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private individuals		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Gray	
14. MOTHER'S MAIDEN NAME Louise Breckinridge		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Richard S. Gray/ Washington, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of Aorta</u> (c) <u>Crushed chest + fracture of neck</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>passenger in car which</u>		20c. TIME OF INJURY Month, Day, Year 5:52 p.m. 10-14 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) Rockville, Md.		20g. (County) Montgomery		20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/61		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park., Rockville, Md.		22d. LOCATION (City, town, or country) Rockville, Md.		23. FUNERAL DIRECTOR Robert L. Snowden	
24a. REC'D BY REGISTRAR DATE OCT 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna		24c. CHIEF MEDICAL EXAMINER Frank J. Broschaw		24d. ASS STANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		24e. DATE SIGNED 10-15-61	

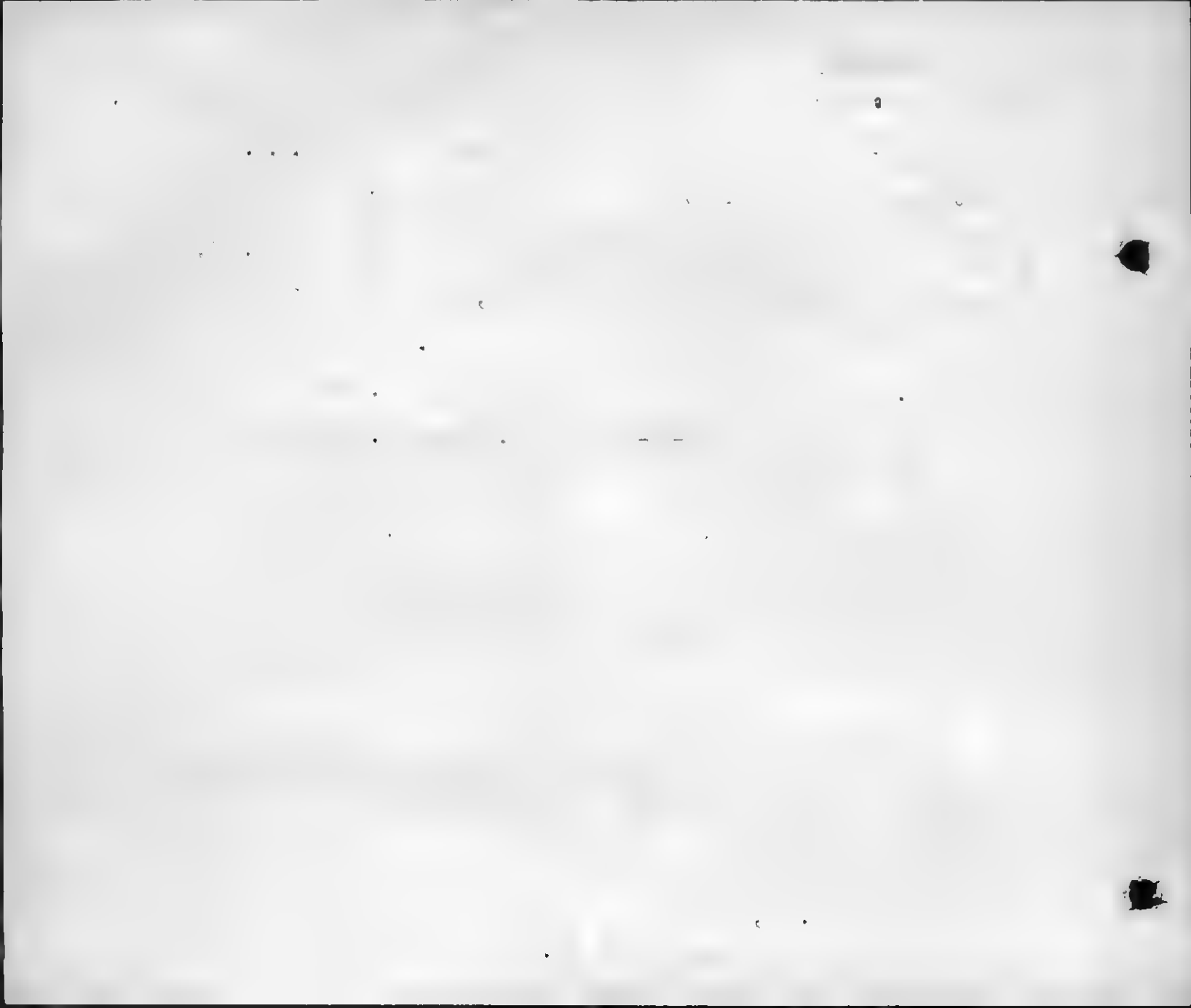


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11578

11563

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 57 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield		R.F.D. # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 1 Gaithersburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Jacob Last Green				4. DATE OF DEATH Month Oct. Day 13, Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1888	
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months 73 Days 19		IF UNDER 24 HRS Hours 19 Min 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph L. Green				14. MOTHER'S MAIDEN NAME Catherine R. Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-22-2134		17. INFORMANT Mrs. Charles J. Green		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 130.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PULMONARY INFARCTION DUE TO (c) ARTERIO SCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS, EMPHYSEMA.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Oct 13 , 1961, that (I) (we) first saw the deceased alive on Oct 13 , 1961, and that death occurred 8:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. F. Meadows, MD				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) G. F. MEADOWS, MD	
22d. ADDRESS DAMASCUS, MD				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Wesley Grove		23d. LOCATION (City, town, or county) (State) Woodfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				25a. REC'D BY REGISTRAR DATE OCT 18 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11579

11564

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>29 yrs</u>				d. STREET ADDRESS <u>806 White Oak</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Charles</u> First <u>Hackman</u> Middle <u>Hackman</u> Last				4. DATE OF DEATH <u>Oct</u> Month <u>31</u> Day <u>1961</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inventor Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claus Hackman</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-4840</u>		17. INFORMANT <u>Mr. Lorrain Hackman</u> Address <u>1111 1/2 St. N.E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH <u>10/31/61</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>attacks</u> DUE TO (c) <u>11/2/56 - 3/22/57</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/17/48</u> to <u>10/31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>61</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T. Morse</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse M.D.</u>	
22d. ADDRESS <u>7630 Calverton Rd. Takoma Park, Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>State of Heaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

CERTIFICATE OF DEATH

11580

11565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Jan Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1835 A. St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Winnie Ida Hall</u> 5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 15, 1888</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>10 - 28 - 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf.</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henley</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Martha McDonald</u> Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis & Pulm. Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Insufficiency - with narrowing</u> (c) <u>Myocardial Infarction - Recent</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus + Large Kidneys</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>? Years</u> <u>? 3-4 wks.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 18, 1961</u> , to <u>Oct 28, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>Oct 27, 1961</u> , and that death occurred at <u>755 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		22b. DATE SIGNED <u>10/28/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7600 Carroll Ave. T.P., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 31, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>Walter S. Hanna</u> 25b. REGISTRAR'S SIGNATURE DATE <u>OCT 31 '61</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



11581

CERTIFICATE OF DEATH

Reg. Dist. No.

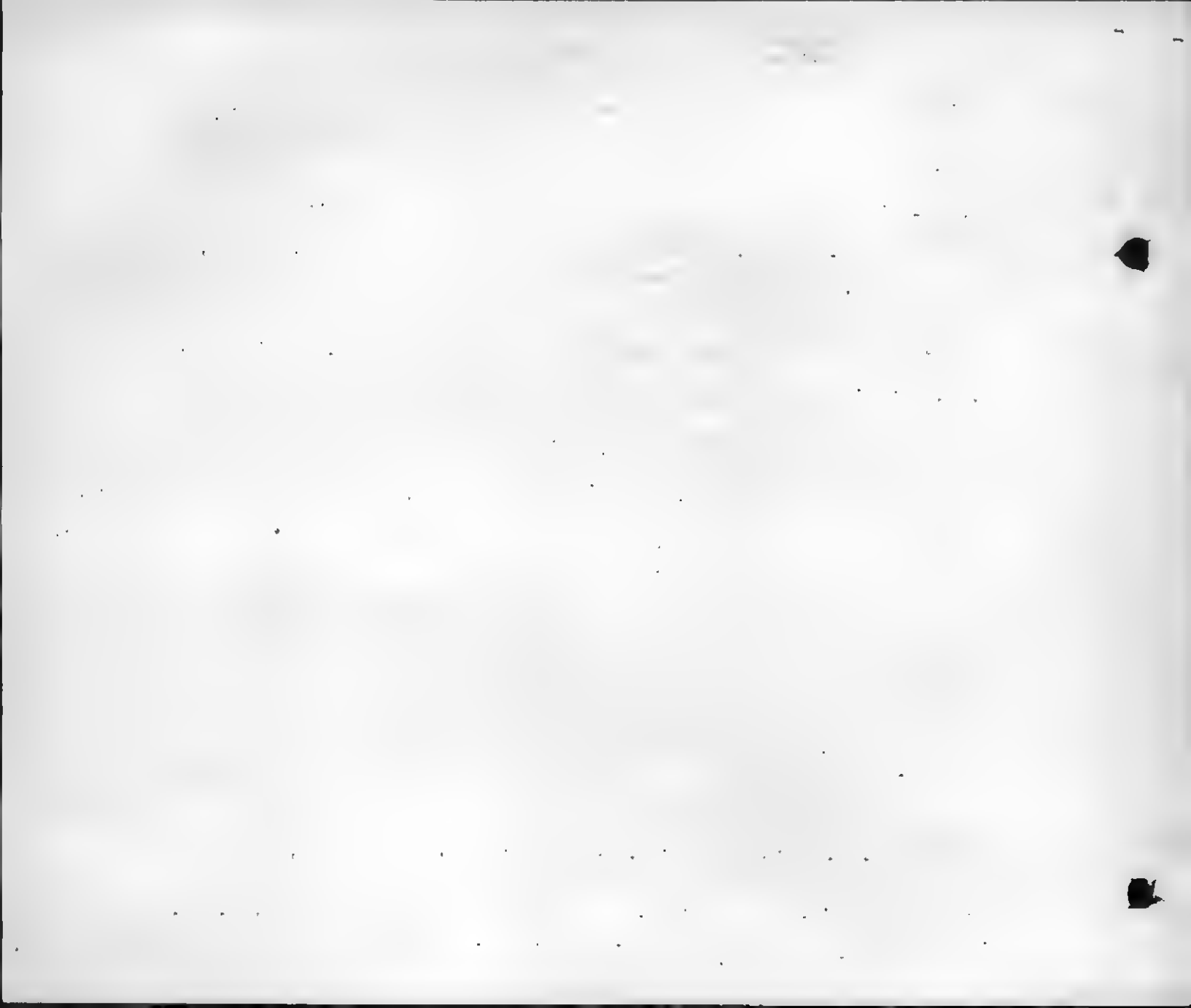
11566

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS Congressional Airport e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys G. Halterman First Middle Last		4. DATE OF DEATH October 19, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/94 9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Lost City, W. Virginia
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME J. F. Garrett	
14. MOTHER'S MAIDEN NAME Nettie Miley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO None		INFORMANT Roy Halterman-Item# 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchial Pneumonia DUE TO (b) Symphocytic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/14/61 to 10/20/61 , that I last saw the deceased alive on 10/20/61 , and that death occurred at 10/20/61 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/20/61			
ACTUAL SIGNATURE W. S. Murphy M.D.		PHYSICIAN'S NAME (Type) W. S. Murphy 615 W. Montgomery Avenue, Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 10/21/61	22c. NAME OF CEMETERY OR CREMATORY Oliver	22d. LOCATION (City town, or county) (State) Moorefield, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE tyson wheeler Home-1331 E. Montg. Ave. Rockville, Maryland		24a. REC'D BY REGISTRAR 10/23/61 DATE	24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



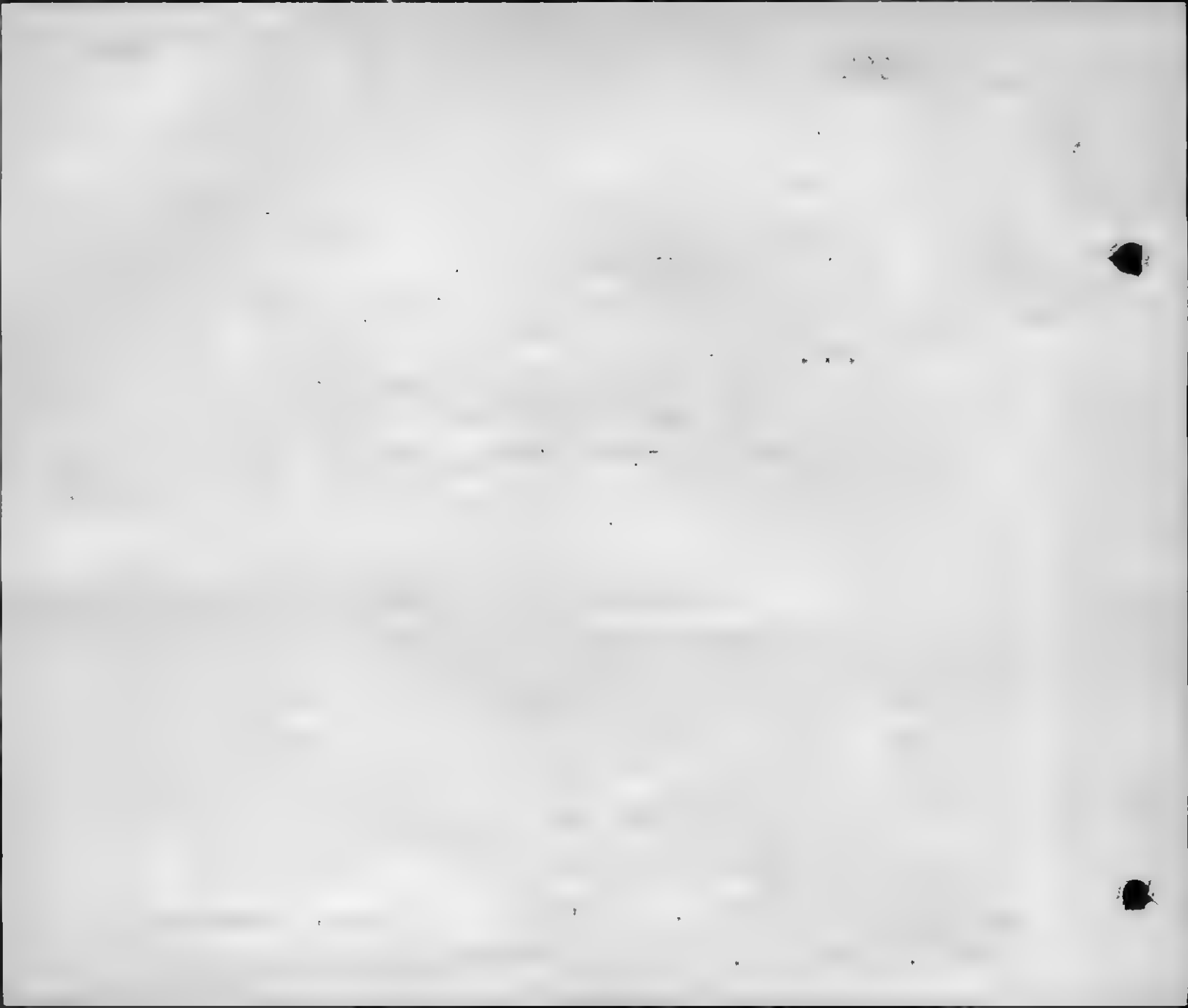
TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11567									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>104 Croyden et. apt 7</u>					d. STREET ADDRESS <u>104 Croyden et. apt 7</u>				
3. NAME OF DECEASED (Type or print) <u>Thomas HANLEY</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>Male</u>					DATE OF DEATH <u>Oct 17 1961</u>				
6. COLOR OR RACE <u>white</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>					8. DATE OF BIRTH <u>10-29-1889</u>				
10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>					9. AGE (in years) (If under 1 year, last birthday) <u>71</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Thomas Hanley</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Connell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>577-18-9176</u>				
17. INFORMANT <u>Mary Hanley (wife)</u>					Address <u>104 Croyden et. apt 7</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 17-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>17-1</u> (a), stating the underlying cause last. DUE TO (c) <u>17-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. <u>History of previous heart disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22. TIME OF INJURY Month, Day, Year 19 <u>10</u> <u>17</u> <u>61</u> 22d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
23. ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. 24. DEPUTY MEDICAL EXAMINER <u>FRANK J. Broschart</u> DATE SIGNED <u>10-17-61</u>									
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u> 25b. DATE THEREOF <u>10/21/61</u> 25c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Cemetery</u> 25d. LOCATION (City, town, or country) (State) <u>Groton, New York</u>									
26. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u> 26b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> 26c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u> 26d. DATE <u>OCT 19 '61</u> 26e. SIGNATURE <u>Arthur S. Kenna</u>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11583

CERTIFICATE OF DEATH

11568

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 25 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Princess Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> 3 d. STREET ADDRESS <u>4126 Little Creek Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Addie Herman Hanna</u>		4. DATE OF DEATH <u>Oct 1</u> 19 <u>61</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/25/82</u>		9. AGE (in years last birthday) <u>79</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Isiah Herman</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO <u> </u> 17. INFORMANT <u>Robt. E. Hanna</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY OBSTRUCTION</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHO PNEUMONIA</u> DUE TO (c) <u>STASIS (BED REST), OBESITY AND SENILITY</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Ex HIP</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING IN CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>FALL FROM CHAIR AT HOME</u>					
20c. TIME OF INJURY Month, Day, Year <u>9/6/61</u> Hour a.m. <u>9:20</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>KENSINGTON</u>			
20f. (City or town) <u>KENSINGTON</u>		20g. (County) <u>MD</u>		20h. (State) <u>MD</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>9/6/61</u> , 19 <u>61</u> , to <u>10/1/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE L. RIVAT MD</u>			
22d. ADDRESS <u>10620 GEORGIA AVE, S.S., Md</u>		23a. NAME OF CEMETERY OR CREMATORY <u>Princess Anne</u>					
23b. DATE OF REMOVAL (Specify) <u>10/4/61</u>		23c. LOCATION (City, town or county) <u>Norfolk</u>		23d. (State) <u>Va</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 11569

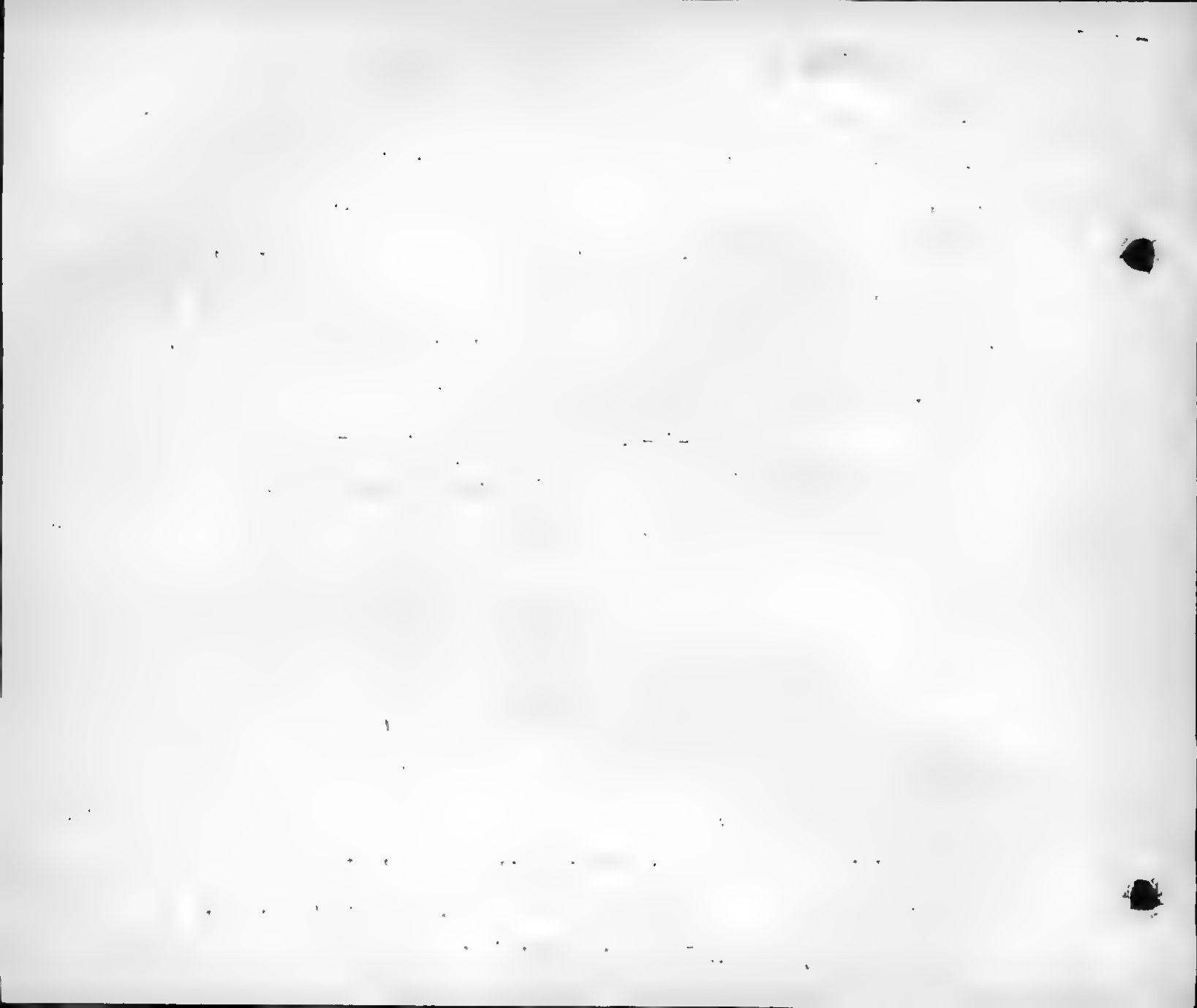
11584

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14178 Travilah Road		d. STREET ADDRESS 14178 Travilah Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDDIE B. HARDING		4. DATE OF DEATH Month Oct. Day 19, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/99
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John E. Harding		14. MOTHER'S MAIDEN NAME Anna King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-01-2806	
INFORMANT Cora Louise Harding-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Emphysema DUE TO (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 6 mon 102yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Oct 1961 to 19 Oct 1961 , that I last saw the deceased alive on 19 Oct 1961 , 1961, and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019/61 DATE SIGNED 10/19/61			
ACTUAL SIGNATURE W.S. Murphy		M.D.	
PHYSICIAN'S NAME (Type) W.S. Murphy		615 W. Montg. Ave., Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/61	
22c. NAME OF CEMETERY OR CREMATORY Darnestown Church Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland		24a. RECEIVED BY REGISTRAR DATE OCT 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

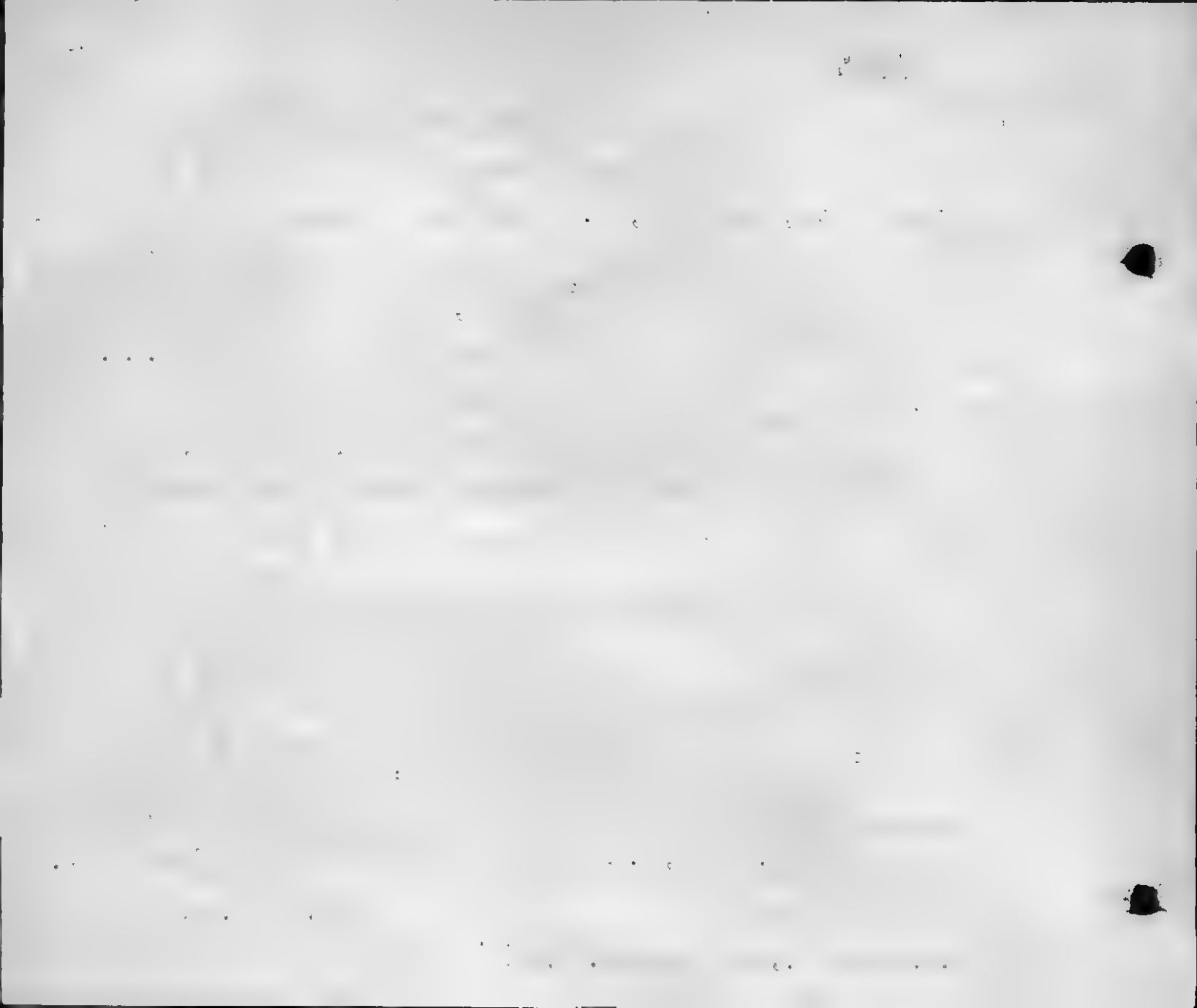
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11585

CERTIFICATE OF DEATH

11570

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>53 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Beckley</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>304 Rural Acres Drive</u> d. STREET ADDRESS <u>304 Rural Acres Drive</u>		3. NAME OF DECEASED (Type or print) <u>Sandra Kay Harmon</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1945</u>		9. AGE (in years - if under 1 year, last birthday) Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE County & State, or foreign country <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Tasker G. Harmon</u>	
14. MOTHER'S MAIDEN NAME <u>Ethel Douglas</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congenital heart disease - Ventricular septal defect</u> 154.2 DUE TO (b) <u>Post-Operative closure of ventricular defect</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>16 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 13, 1961</u> to <u>October 5, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 5, 1961</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Benson R. Wilcox</u>		22b. PHYSICIAN'S NAME (Type) <u>Benson R. Wilcox, M.D.</u>		22c. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		22d. DATE SIGNED <u>10/6/61</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beckley, W. Va.</u>		23d. LOCATION (City, town or county) <u>Beckley, W. Va.</u>		23e. REC'D BY REGISTRAR <u>October 9 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</u>		24b. ADDRESS <u>Wash, D.C.</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		24d. DATE <u>OCT 9 '61</u>		24e. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



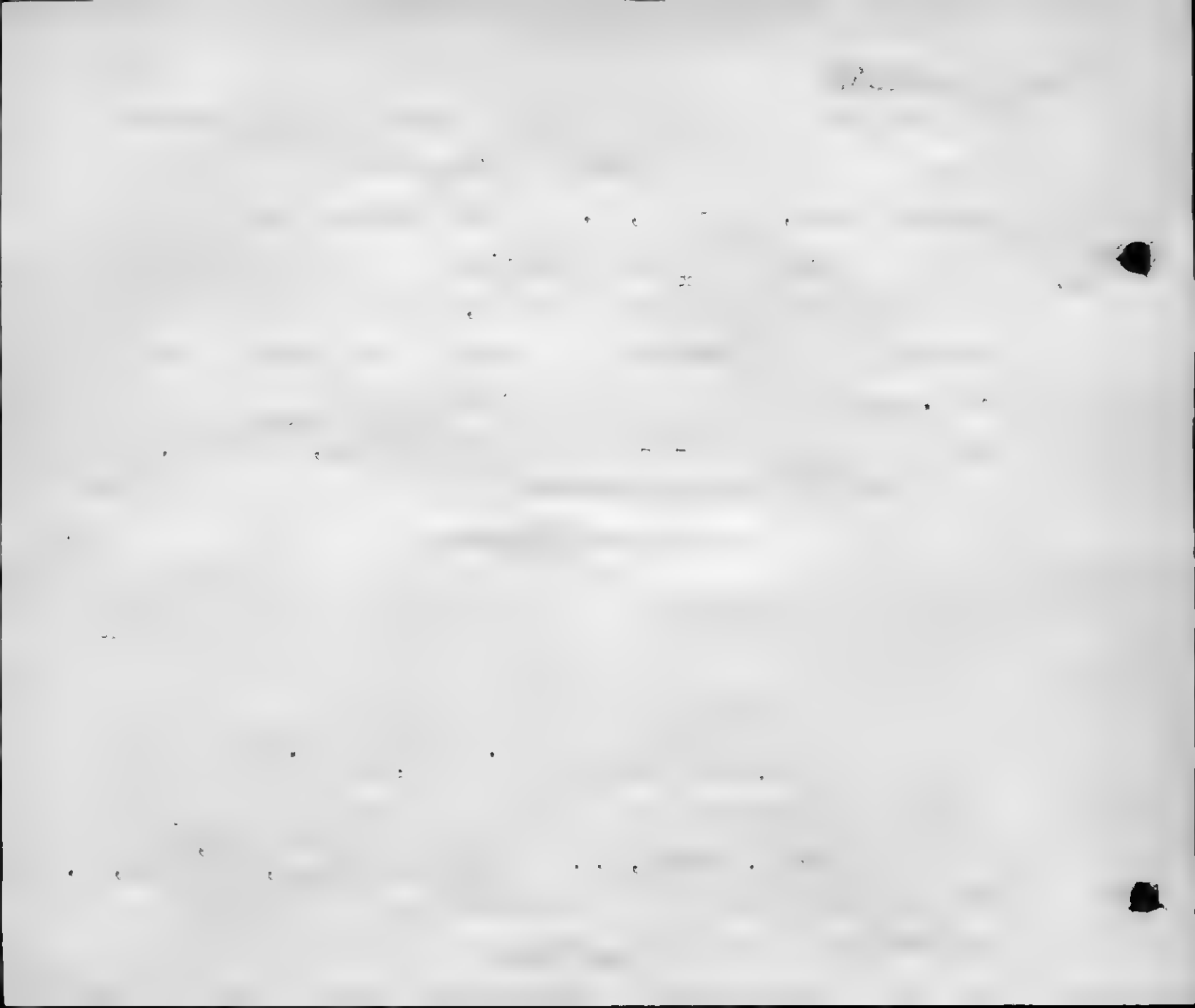
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

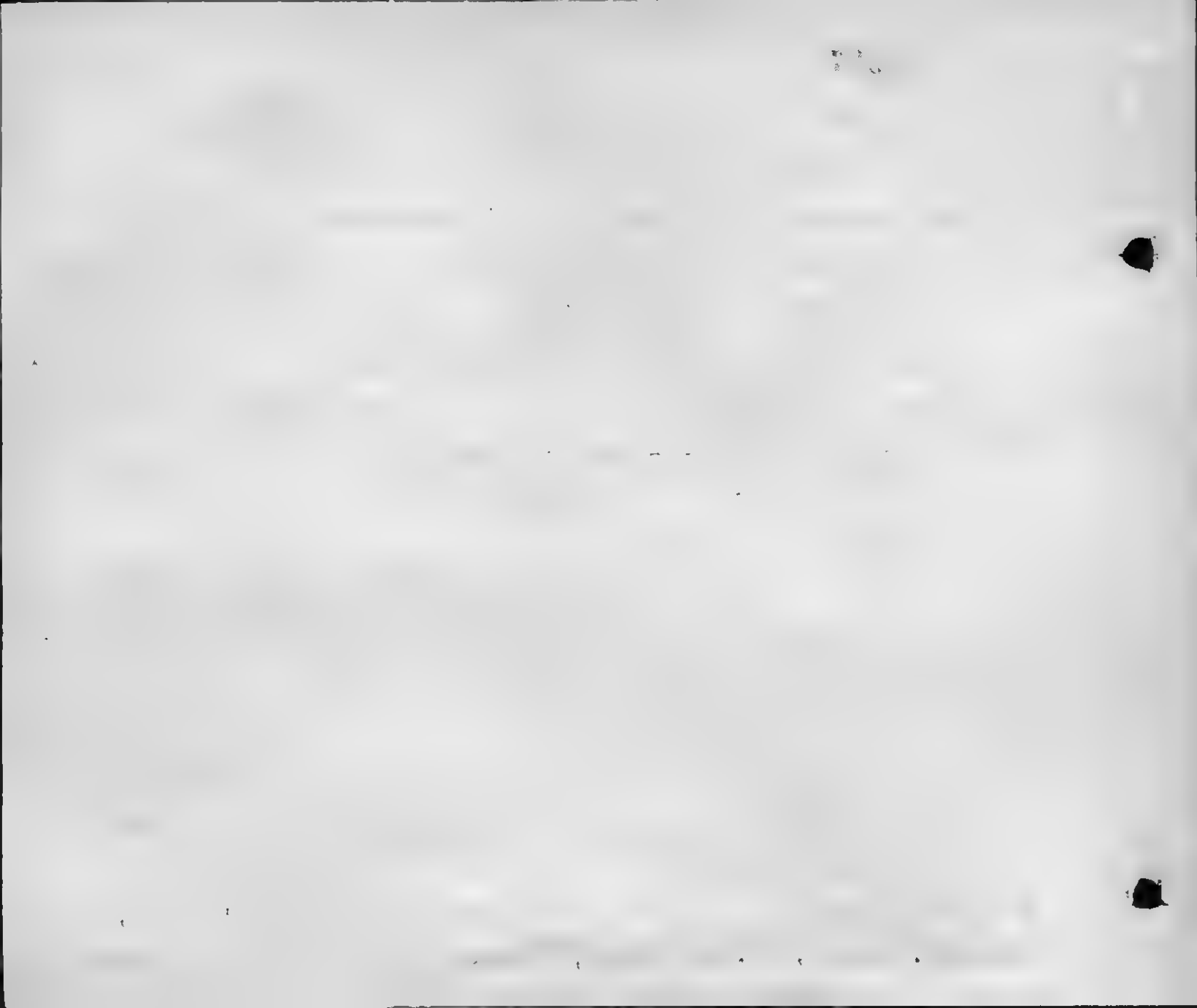
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs	
c. LENGTH OF STAY IN 1b 11 days		d. STREET ADDRESS 14511 Colesville Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Harrison		4. DATE OF DEATH October 28 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1918	
9. AGE (In years; last birthday) 43 yrs.		10. IF UNDER 1 YEAR: Months 14 Days 1 Year 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Illinois (County unknown)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Harrison		14. MOTHER'S MAIDEN NAME Mildred Chapin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 288-14-5945	
17. INFORMANT'S ADDRESS The Medical Record The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia (b) Cerebellar hemangioblastoma (c) 141.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 141.9 DUE TO (c) 141.9	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Thomas A. Waldmann (this hospital) attended the deceased from Oct. 17 to Oct. 28 , 1961, that (X) (we) last saw the deceased alive on Oct. 28 , 1961, and that death occurred at 7:03AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Waldmann, M.D.		22b. DATE SIGNED 10/28/61	
22c. PHYSICIAN'S NAME (Type) Thomas A. Waldmann, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 31, 1961	
23c. NAME OF CEMETERY OR CREMATORY Wash. National		23d. LOCATION (City, town or county) (State) P.M. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chanley Co.		25a. REC'D BY REGISTRAR OCT 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Huns		25c. ADDRESS 517-11th St. S.E. Wash, D.C.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Indiana</u> b. COUNTY <u>Indianapolis</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indianapolis</u>					
c. LENGTH OF STAY IN TB <u>4 weeks</u>						d. STREET ADDRESS <u>5935 Kessler Lane</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Haven Convalescent Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Killen F. Hawkins</u>						4. DATE OF DEATH <u>Oct. 1 1961</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 16, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George M. Heighton</u>						14. MOTHER'S MAIDEN NAME <u>Anna Small</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>535-12-3891</u>					
17. INFORMANT <u>Mrs Peter Ternick, 416 Hillsboro Dr. Silver Sp. Md.</u>						Address <u></u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>Heart Murmuring</u>											
Conditions, if any, which gave rise to immediate cause (b) <u>Cyanide</u>											
(c) <u>Parkinson's Syndrome</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1961</u> to <u>Oct 1, 1961</u> , that (I) (was) last saw the deceased alive on <u>Sept 28, 1961</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas H. Volition</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>10/1/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Volition</u>						22d. ADDRESS <u>7401 Blair Rd NW Wash D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>10/3/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Prince George's County, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumfrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>						25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

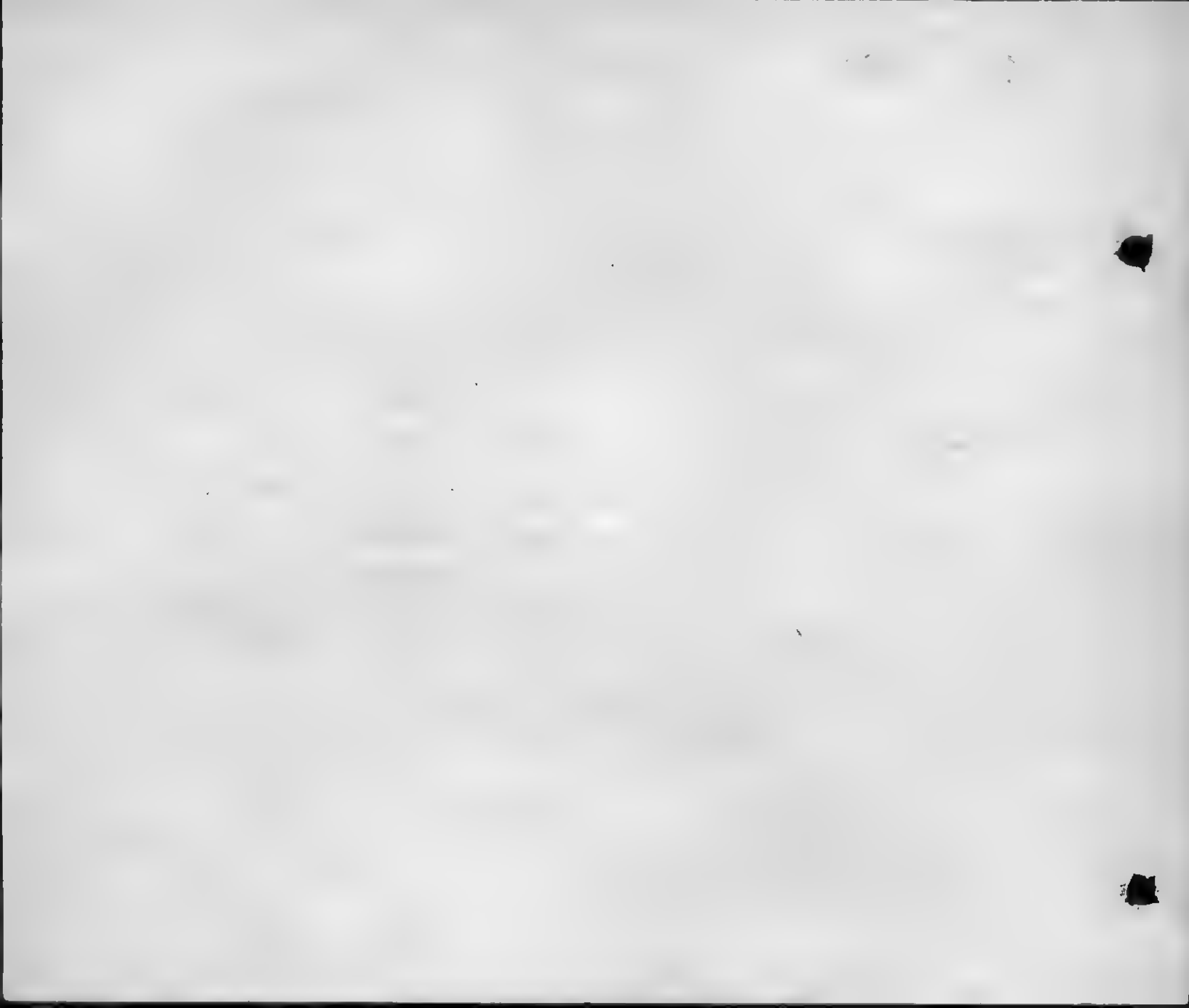
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11588

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN, AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-PERMIT. THEN PLEASE REMOVE CARBON PAPERS, PAGES 1 AND 2 SHOULD BE FILLED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>8711 Grant Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R.</u> Last <u>Hayden</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>15</u>	
11. IF UNDER 24 HRS.: Hours <u>12</u> Min. <u>30</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance adjuster</u>	
13. FATHER'S NAME <u>Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fitzgerald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>578-10 9325</u>	
17. INFORMANT <u>Rose Hayden</u>		Address <u>Above (W. 30)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Pulmonary infarction, lt. lobe</u> <u>Pulmonary thrombosis, lt</u> <u>Obtuse Coronary insufficiency</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Polymorphitis (nutritional?)</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Allen J. O'Neill MD</u>		22b. DATE SIGNED: <u>Oct 4 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>		22d. ADDRESS <u>5601 Old Georgetown Rd Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		23d. LOCATION (City, town or county) (State) <u>Ft. Myer, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>		25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>	
ADDRESS <u>517 W. 34 St SE Washington D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

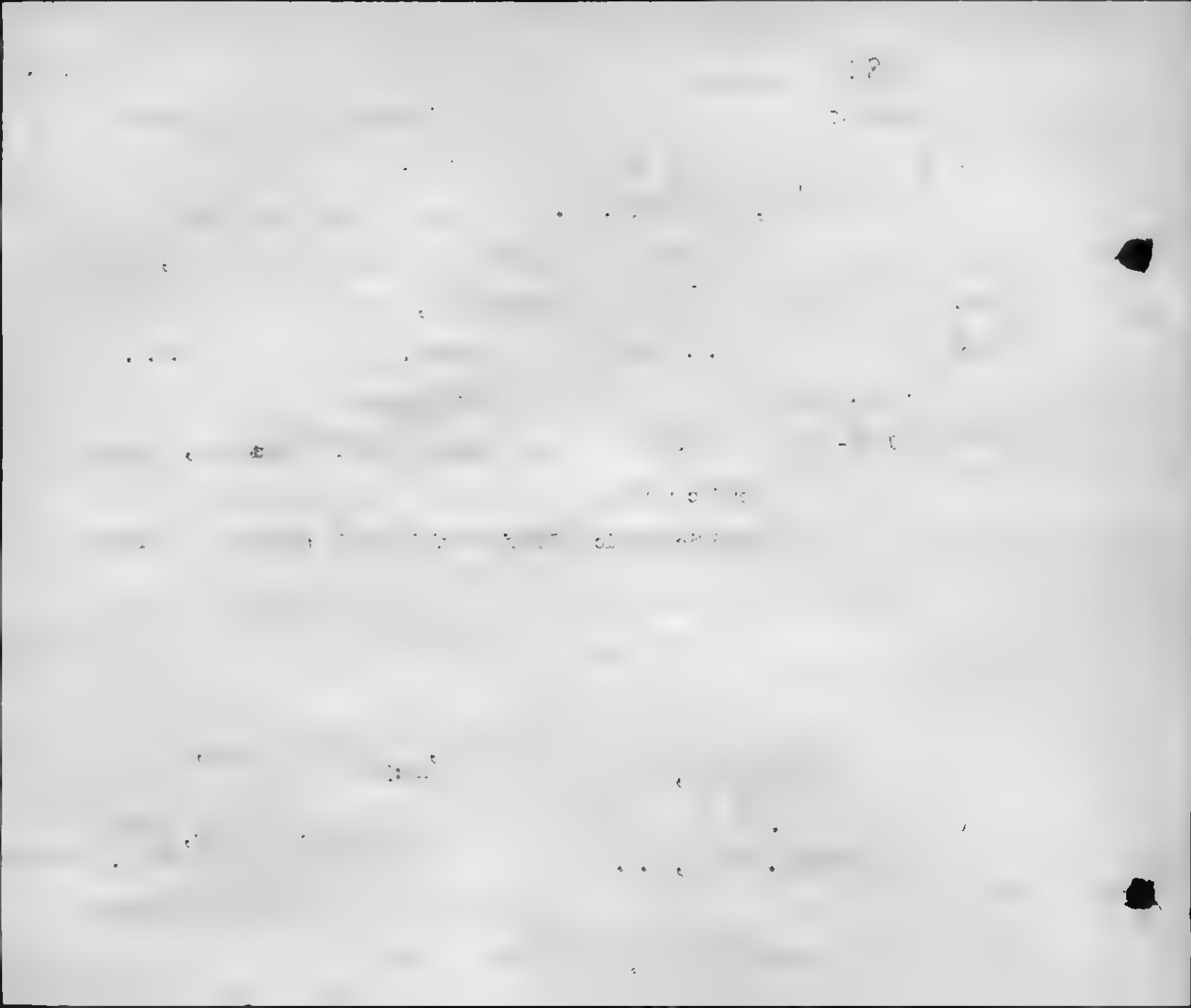
CERTIFICATE OF DEATH

11589

Item 22a Film G298 10/20/61

11574

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution; Res. dance before adm. ssion) a. STATE Virginia		b. COUNTY Norfolk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 5109 East Princess Anne Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Leonard Heath		4. DATE OF DEATH October 21, 1961		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 19, 1906	
9. AGE (In years, last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 12 Min. 30		11. IF UNDER 24 HRS. Hours 12 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (County & State, or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eric N. Heath		14. MOTHER'S MAIDEN NAME Tilda Abeldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1925-1955		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Calcific aortic valvulitis with aortic stenosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 421-1		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 		20g. (County) 		20h. (State) 	
21. I certify that (I) (this hospital) attended the deceased from October 9, 1961 to October 21, 1961 , that (I) (we) last saw the deceased alive on October 21, 1961 , and that death occurred 12:30AM from the causes and on the date stated above.		22a. SIGNATURE Kenneth L. Melman M.D.		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type) KENNETH L. MELMAN, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Maryland		22e. REC'D BY REGISTRAR 	
22f. REGISTRAR'S SIGNATURE 		22g. DATE OCT 25 '61		22h. REGISTRAR'S SIGNATURE 	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Oct. 25, 61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington, Virginia		23e. (State) 		23f. (Country) 	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Murphy		24a. ADDRESS 3524 Columbia Pike, Arlington, Virginia		24b. (City, town or county) 	
24c. (State) 		24d. (Country) 		24e. (Country) 	



11590

CERTIFICATE OF DEATH

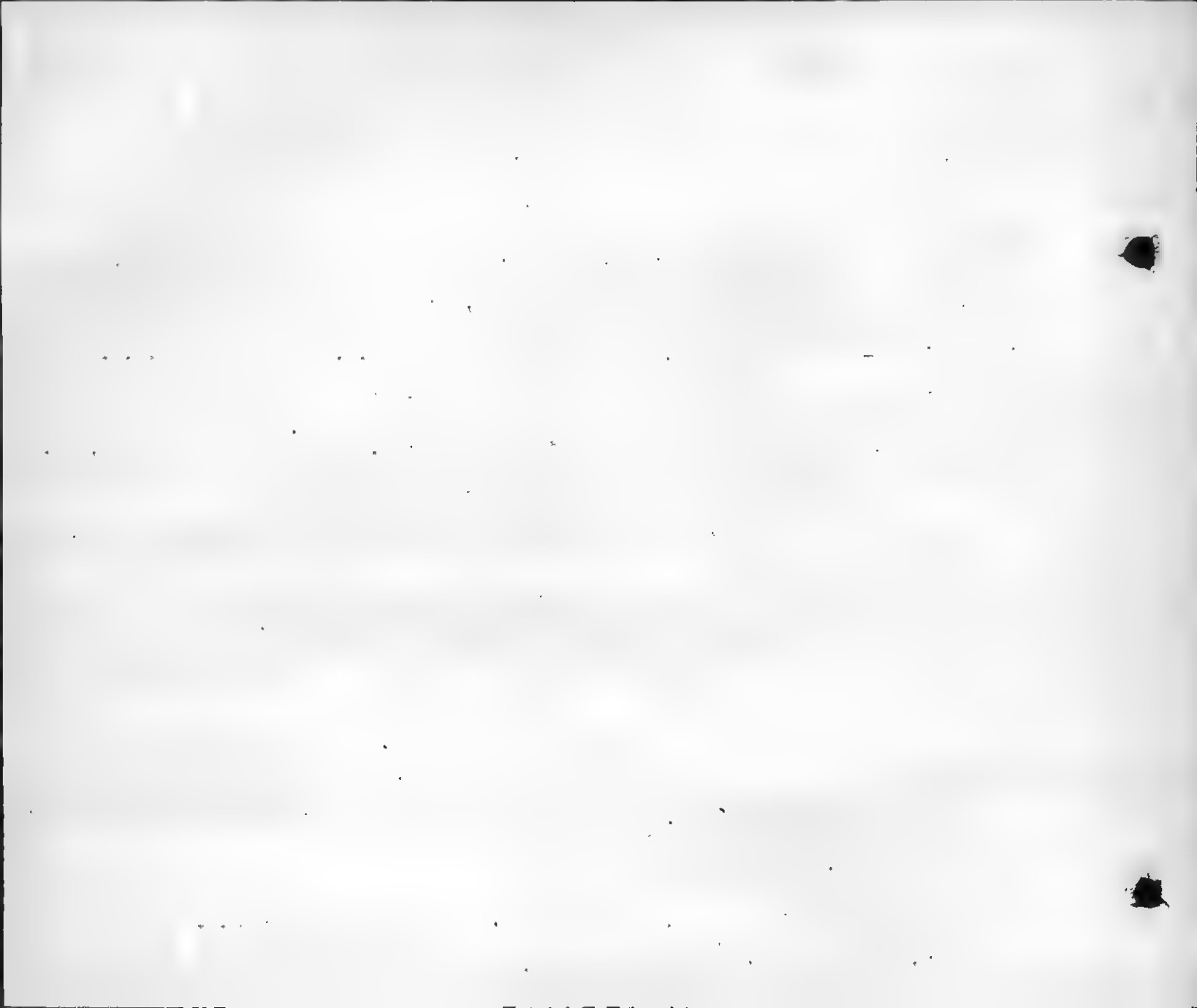
Reg. Dist. No.

11575

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b six months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 733 Sligo Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 733 Sligo Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Bernadette Hellmuth		4. DATE OF DEATH Month Day Year October 6, 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXX Clerk-Retired		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Interior Washington D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Langley		14. MOTHER'S MAIDEN NAME Catherine O'Brien	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Catherine I. Hellmuth		Address 733 Sligo Avenue Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 ACUTE PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIOSCLEROTIC HEART DISEASE 3-4YRS (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF COLON WITH METASTASES			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/26 , 19 61 , to 10/6 , 19 61 , that I last saw the deceased alive on 10/6 , 19 61 , and that death occurred at 11:53A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Tuohy M.D. 7720 WISCONSIN AVE, BETHESDA MD 196/61			
ACTUAL SIGNATURE John H. Tuohy		PHYSICIAN'S NAME (Type) John H. Tuohy 7720 Wisconsin Avenue, Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/61	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Pumphrey Inc. Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE OCT 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

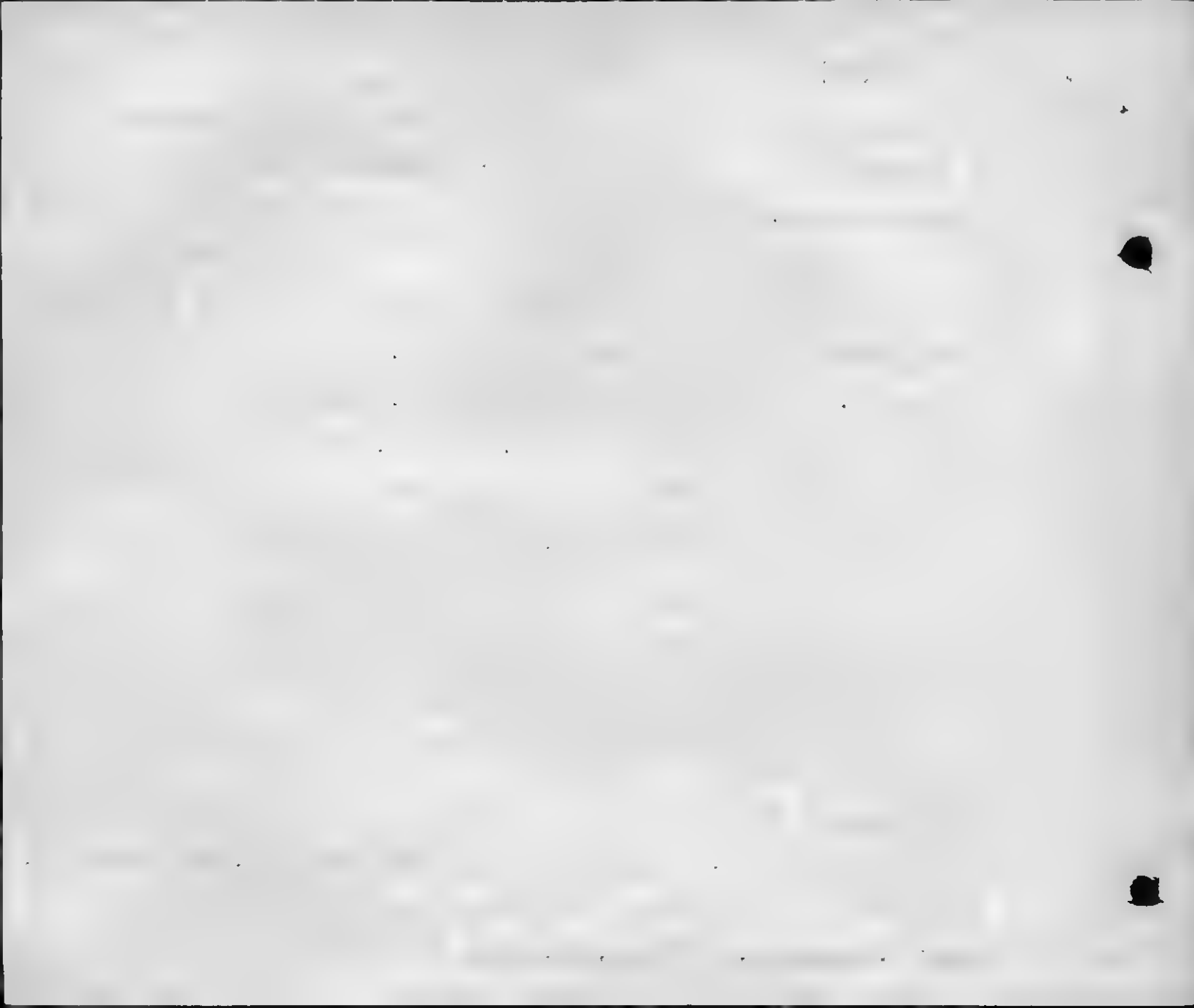
11591

11576

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase d. STREET ADDRESS 3912 Leland Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul Renno Heyl		4. DATE OF DEATH October 22 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1872
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist	11. BIRTHPLACE (County & State, or foreign country) Penna.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist		10b. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry R. Heyl		14. MOTHER'S MAIDEN NAME Mary R. Knauff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Roger W. Jones-Daughter-same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia (b) Mitral insufficiency (c)		INTERVAL BETWEEN ONSET AND DEATH 10 da 5-10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1956 to Oct. 22, 1961 that (I) (we) last saw the deceased alive on Oct. 22, 1961, and that death occurred at 6 PM, from the causes and on the date stated above.			
22a. SIGNATURE Katharine A. Chapman M.D.		22b. DATE SIGNED October 22, 1961	
22c. PHYSICIAN'S NAME (Type) Katharine A. Chapman		22d. ADDRESS 3924 Baltimore Rd. Kensington Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10/23/61	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 24 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

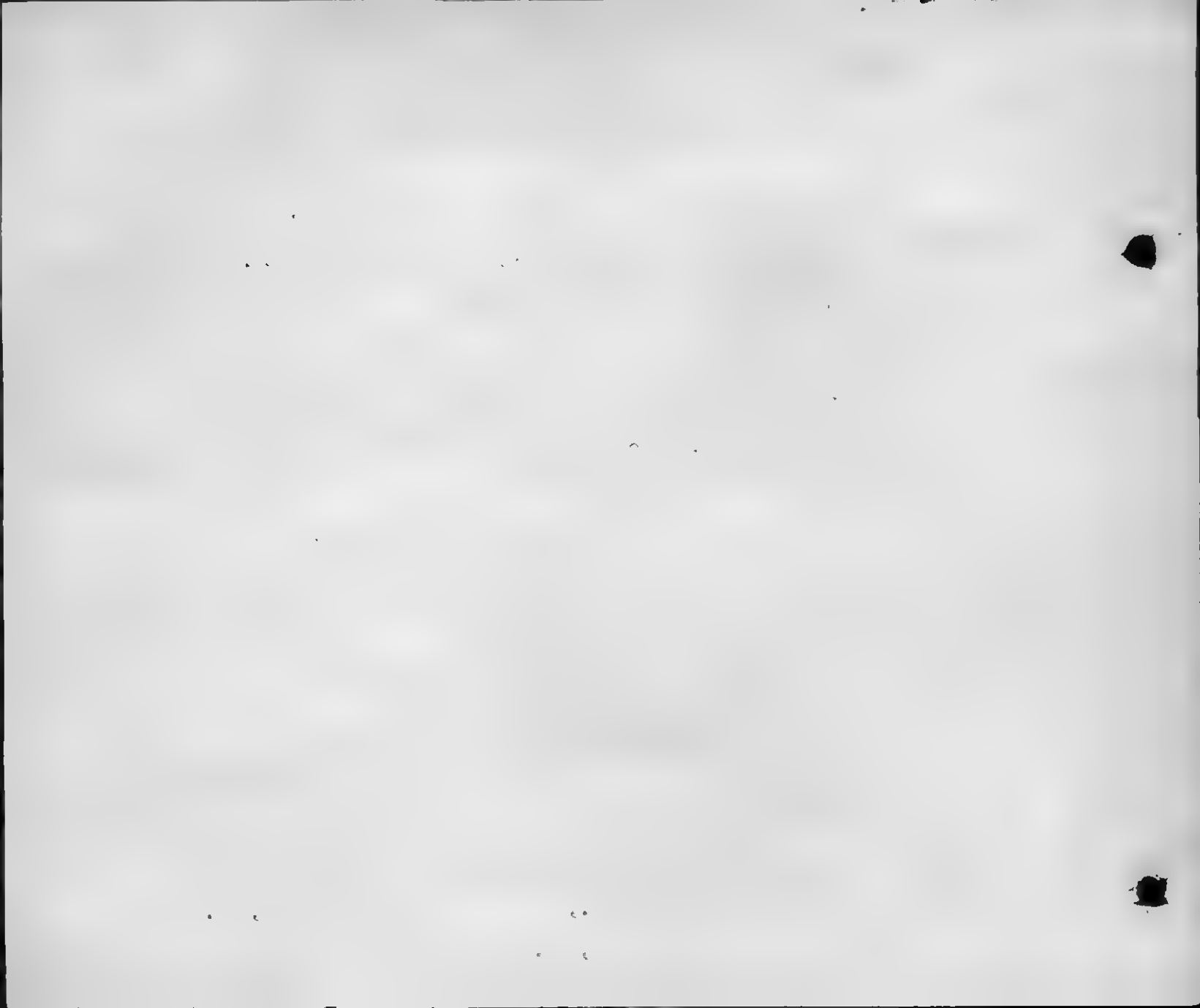


FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or if delay is necessary, within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give full name of the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11592 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11577

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN 1b 17 days		d. STREET ADDRESS 4101 Manor Rd.,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Milton		4. DATE OF DEATH Oct. 10 19 61	
5. SEX male		6. COLOR OR RACE negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/97	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Hicks		14. MOTHER'S MAIDEN NAME Anna Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-46-7254	
17. INFORMANT Sylvester Pitman		Address same as above	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Ischemic Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 16 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Bruchman		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BRUCHMAN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/61	
22c. NAME OF CEMETERY OR CREMATORY Hope Hill.,		22d. LOCATION (City, town, or country) (State) Buckeystown, Md.	
23. FUNERAL DIRECTOR Robert L. Swarden		24a. REC'D BY REGISTRAR 10-10-61	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11593

CERTIFICATE OF DEATH

11578

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>700 Grandin Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>700 Grandin Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>Oct. 3,</u> 19 <u>61</u> 8. DATE OF BIRTH <u>Aug. 26,</u> 1870 9. AGE (in years if UNDER 1 YEAR; if UNDER 24 HRS., last birthday) <u>91</u> yrs. <u>1</u> Months <u>7</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>George Dorsey Clark</u> 14. MOTHER'S MAIDEN NAME <u>Alice Linthicum</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Sister</u> <u>Mrs. F. J. LeMoine</u> Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>acute dilatation of heart</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic myocarditis</u> DUE TO (c) <u>cancer right femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>58</u> , to <u>October 3</u> , 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Oct 2</u> , 19 <u>61</u> , and that death occurred at <u>4:56</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert V. Hartley</u> 22c. PHYSICIAN'S NAME (Type) <u>Gilbert V. Hartley</u>		22b. DATE SIGNED <u>Oct. 4, 1961</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>103 Forest Ave., Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/6/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>OCT 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

185.

186.

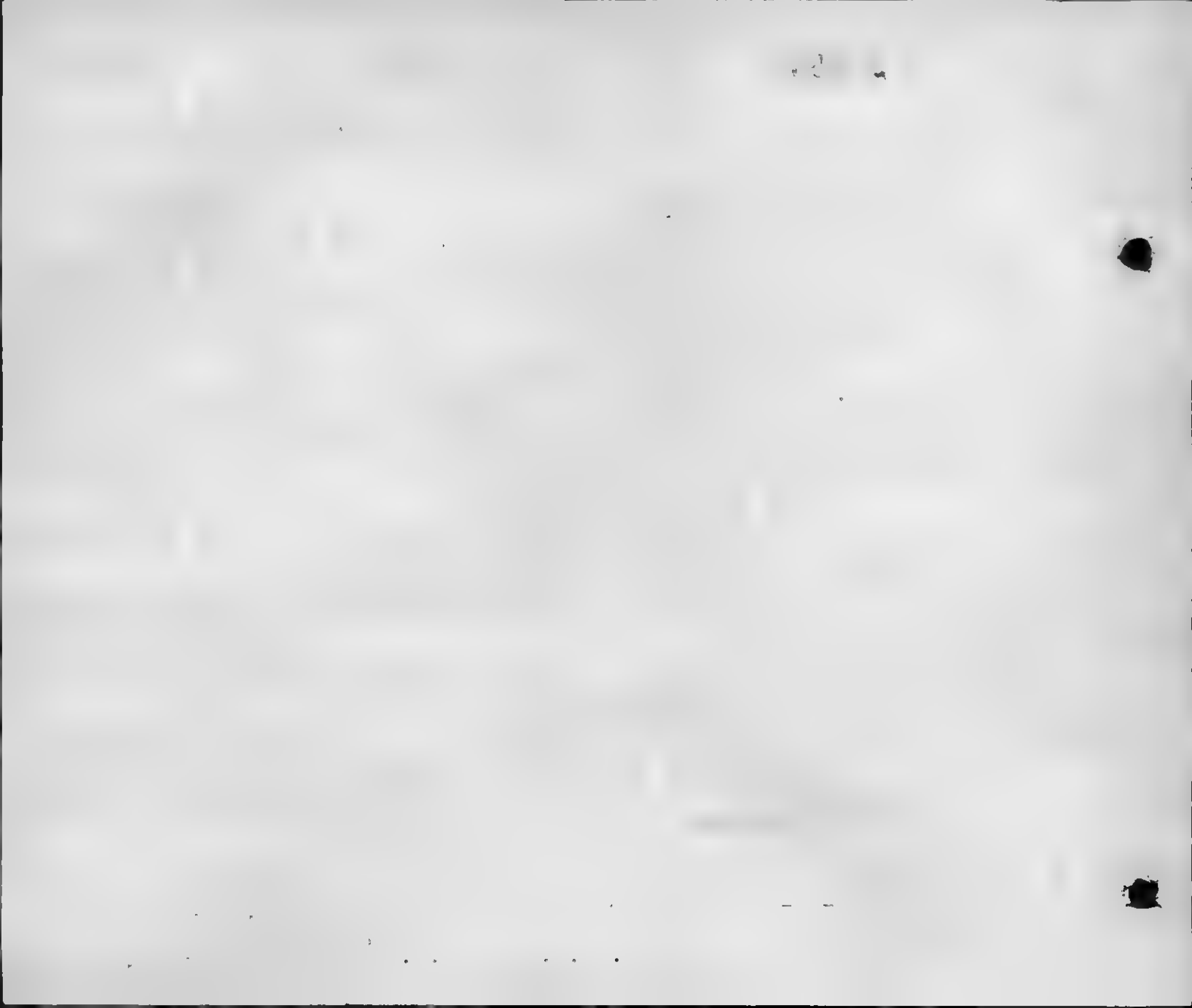


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11594 CERTIFICATE OF DEATH 11579											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sant Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>910 Kennebec Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lillian Catherine Hollidge</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1961</u>							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personelle Mana. People's Drug</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>District of Col.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William E. Krause</u>				14. MOTHER'S MAIDEN NAME <u>Lilla Cross</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>William H. Cross (cousin)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Several years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>October 10</u> , 1961, to <u>October 27</u> , 1961, that (I) (we) last saw the deceased alive on <u>October 27</u> , 1961, and that death occurred <u>at 10:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Stuart B. Nelson</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>10-30-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>300-4th St. N.E. Wash</u>				25a. REC'D BY REGISTRAR <u>OCT 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11595

11580

1. PLACE OF DEATH COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2117 Beechwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George	4. DATE OF DEATH Month 10 Day 7 Year 1961	5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Branch Chief, Army Map Service		10b. KIND OF BUSINESS OR INDUSTRY West Va.		9. AGE (In years last birthday) 51	
13. FATHER'S NAME Walter Lee Hopkins		14. MOTHER'S M.A.DEN NAME Carry Detamore		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Old Record		17. INFORMANT Old Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (b) Cardiac Metastasis from (c) Carcinoma Right Lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathologic Fracture Right Humerus					
20a. ACCIDENT OR UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> ACCIDENT <input checked="" type="checkbox"/> UNDERLYING CAUSE					
20c. TIME OF INJURY Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1015 SPRING STREET, S.S., MD.	
20f. (City or town) Greenwich, Va.		20g. (County) Greenwich		20h. (State) Va.	
21. I certify that (I) (the hospital) attended the deceased from June 1961 to October 7, 1961 , that (I) (we) last saw the deceased alive on Oct 7, 1961 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Marvin L. Kolkin		22b. PHYSICIAN'S NAME (Type) MARVIN L. KOLKIN M.D.		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1015 SPRING STREET, S.S., MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/10/61		23c. NAME OF CEMETERY OR CREMATORY Greenwich Presbyterian Cemetery	
23d. LOCATION (City, town or county) Greenwich, Va.		23e. (State) Va.		23f. (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Himes Co.		24a. ADDRESS 2901-14th St N.E. Washington D.C.		24b. DATE OCT 11 '61	
25a. REGISTRAR'S SIGNATURE Arthur S. Himes		25b. REGISTRAR'S SIGNATURE Arthur S. Himes		25c. DATE OCT 11 '61	

Dr. Broschart contacted. *Consent to sign certificate*

1. The first part of the paper is devoted to a discussion of the

general properties of the A.S.G. (see [1]).

2. In the second part we consider the problem of the construction of the

explicit form of the A.S.G. (see [2]).

3. In the third part we consider the problem of the construction of the

explicit form of the A.S.G. (see [3]).

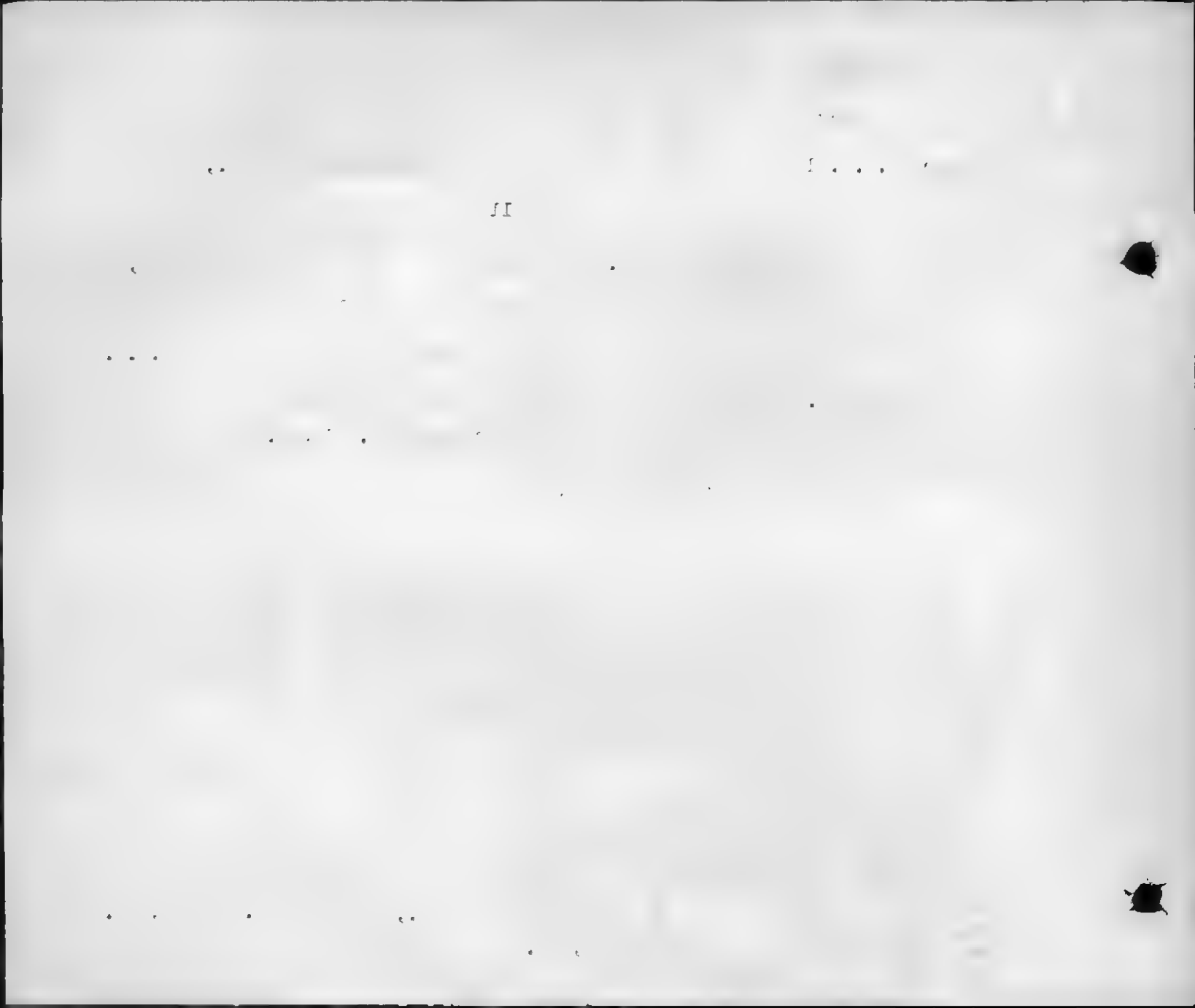
4. In the fourth part we consider the problem of the construction of the

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11596		Item 9 Film G297		10/10/61		11581	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood R.F.D. #1				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Silver Spring.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home				d. STREET ADDRESS 2218 University Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle C. Last Horad				4. DATE OF DEATH Month October Day 2 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 20, 1881	
9. AGE (In years last birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Horad				14. MOTHER'S MAIDEN NAME Belle Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Romeo Horad Sr. item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Hypertensive Cardiovascular Disease DUE TO (b) Chronic Myocarditis DUE TO (c) Chronic Nephritis				INTERVAL BETWEEN ONSET AND DEATH 5 years (?) 5 years +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1953 to Oct 2, 1961 (that (I) (we) last saw the deceased alive on 9/30, 1961 and that death occurred at 5 AM , from the causes and on the date stated above							
22a. SIGNATURE Calvin B. LeCompte				22b. DATE 10/5/61		22c. PHYSICIAN'S NAME (Type) Calvin B. LeCompte	
23a. BURIAL CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 10/7/61		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park..	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR DATE OCT 6 '61		25b. REGISTRAR'S SIGNATURE Robert L. Snowden	
26. ADDRESS Rockville, Md.				27. LOCATION (City, town, or county) (State) Prince Geo. County, Md.			



1
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M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

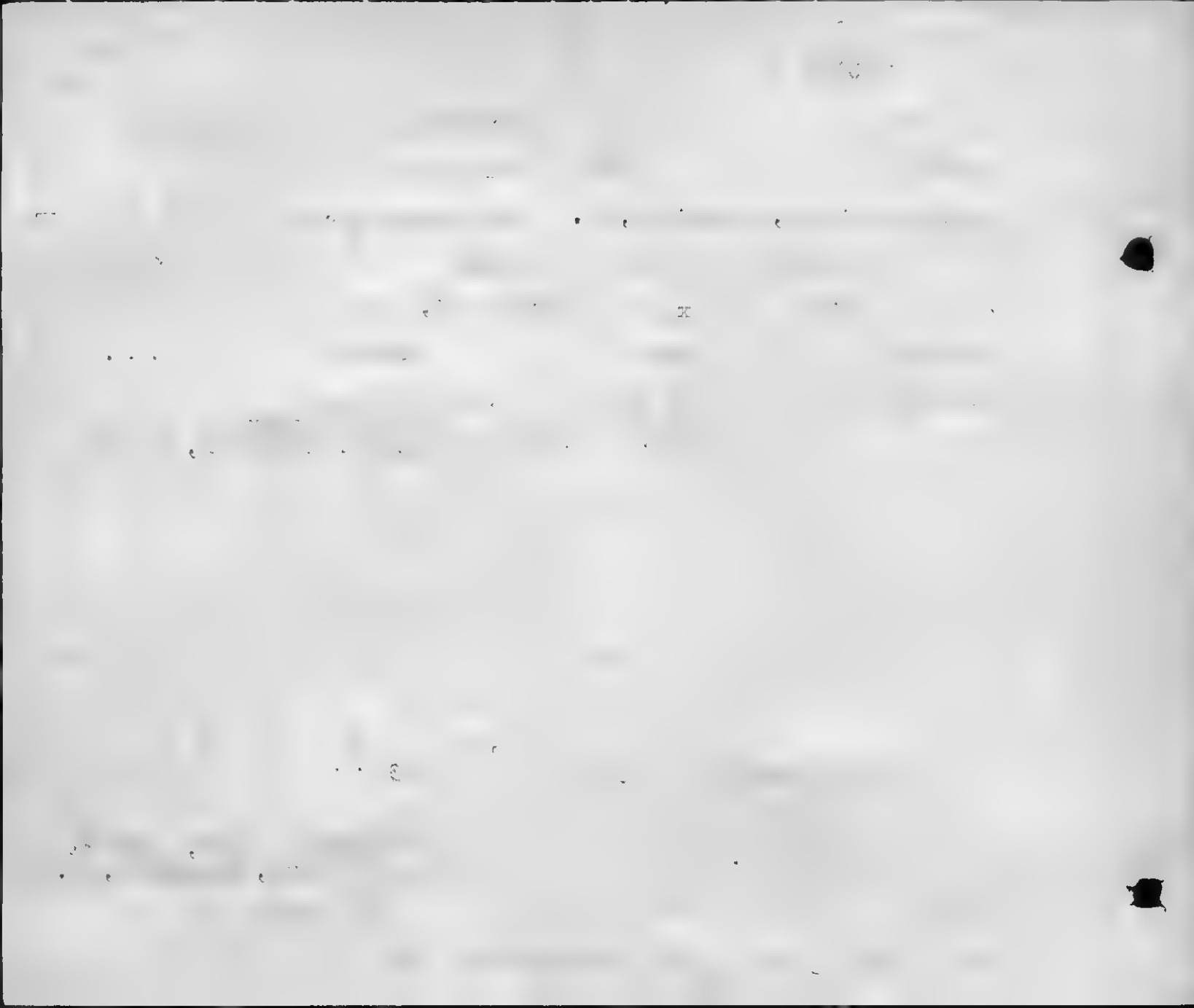
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11597

CERTIFICATE OF DEATH

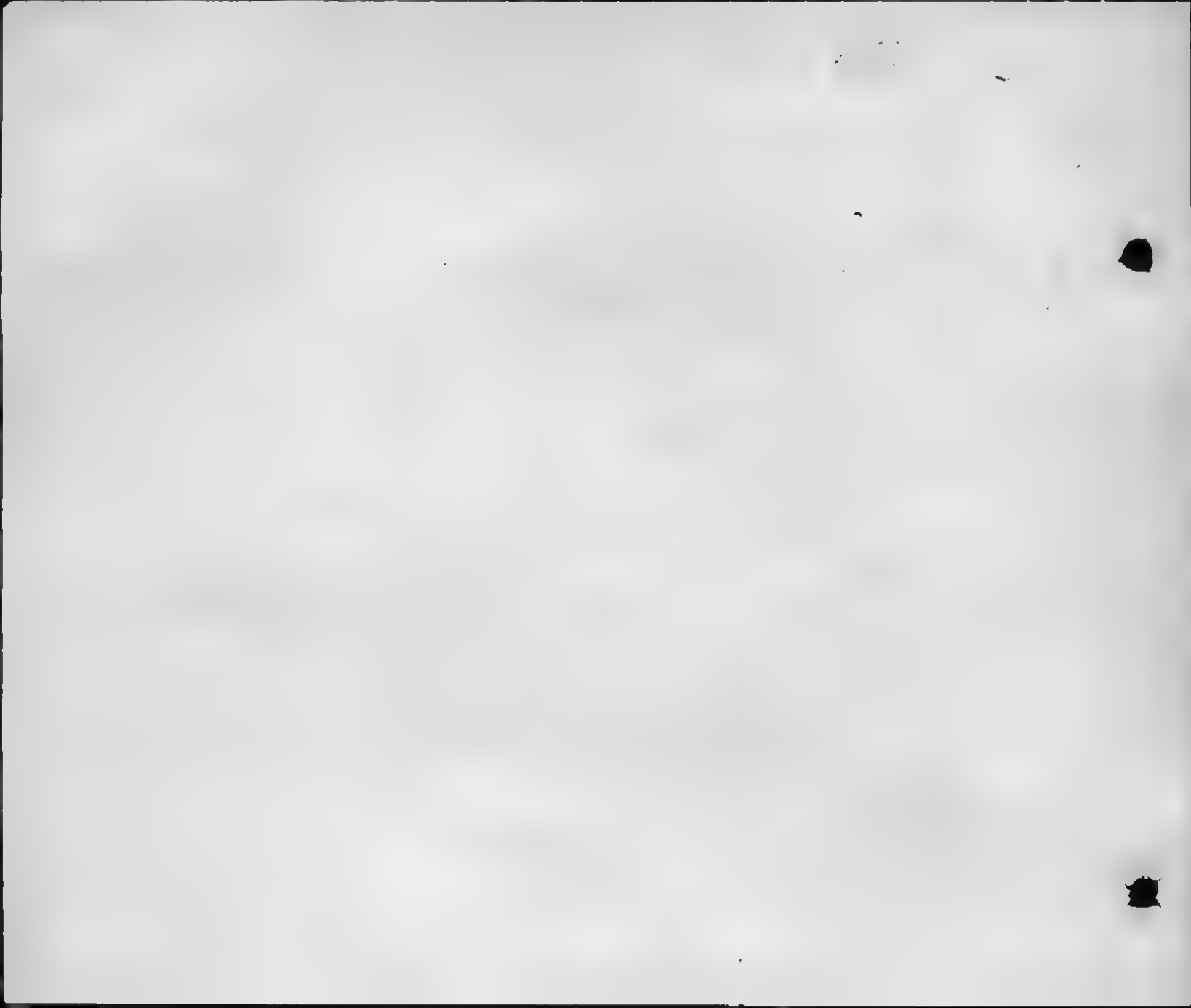
11582

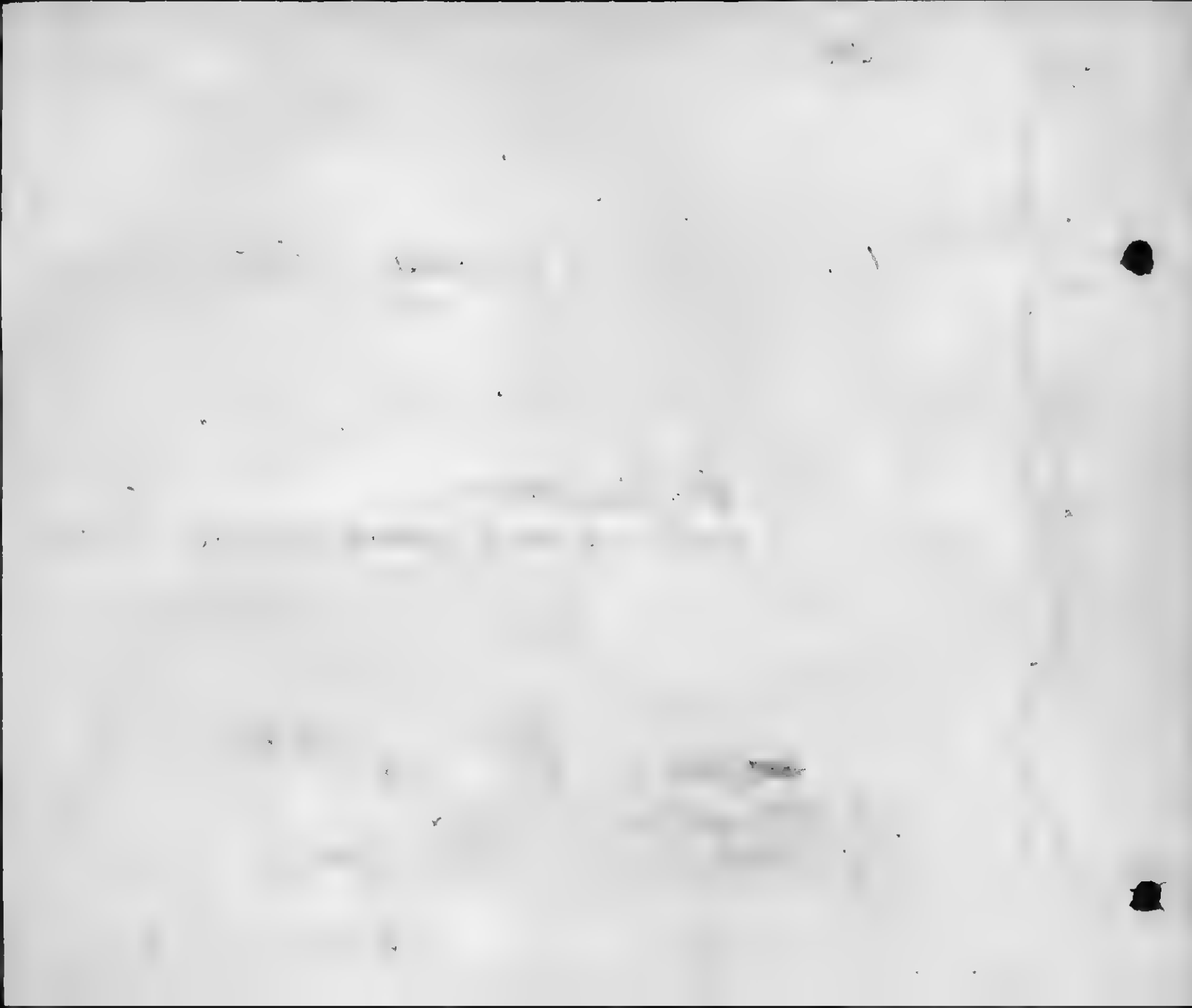
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 82 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 400 Gaithersburg Street	
3. NAME OF DECEASED (Type or print) Bertha First (None) Middle Hough Last		4. DATE OF DEATH October 23 19 61 Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 13, 1893 68 yrs.	
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (Country & State, or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nels Swanson		14. MOTHER'S MAIDEN NAME Katherine Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 2 19 61 to October 23 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 23 19 61 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James D. Prokop 22c. PHYSICIAN'S NAME (Type) James D. Prokop		22b. DATE SIGNED October 24 19 61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/61	
23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery		23d. LOCATION (City, town or county) (State) Portage, PENNA.	
24. FUNERAL DIRECTOR'S SIGNATURE Randolph Leckinger		25a. REC'D BY REGISTRAR OCT 24 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			



VS. A15ME
5M 9/60

Arthur S. Kline





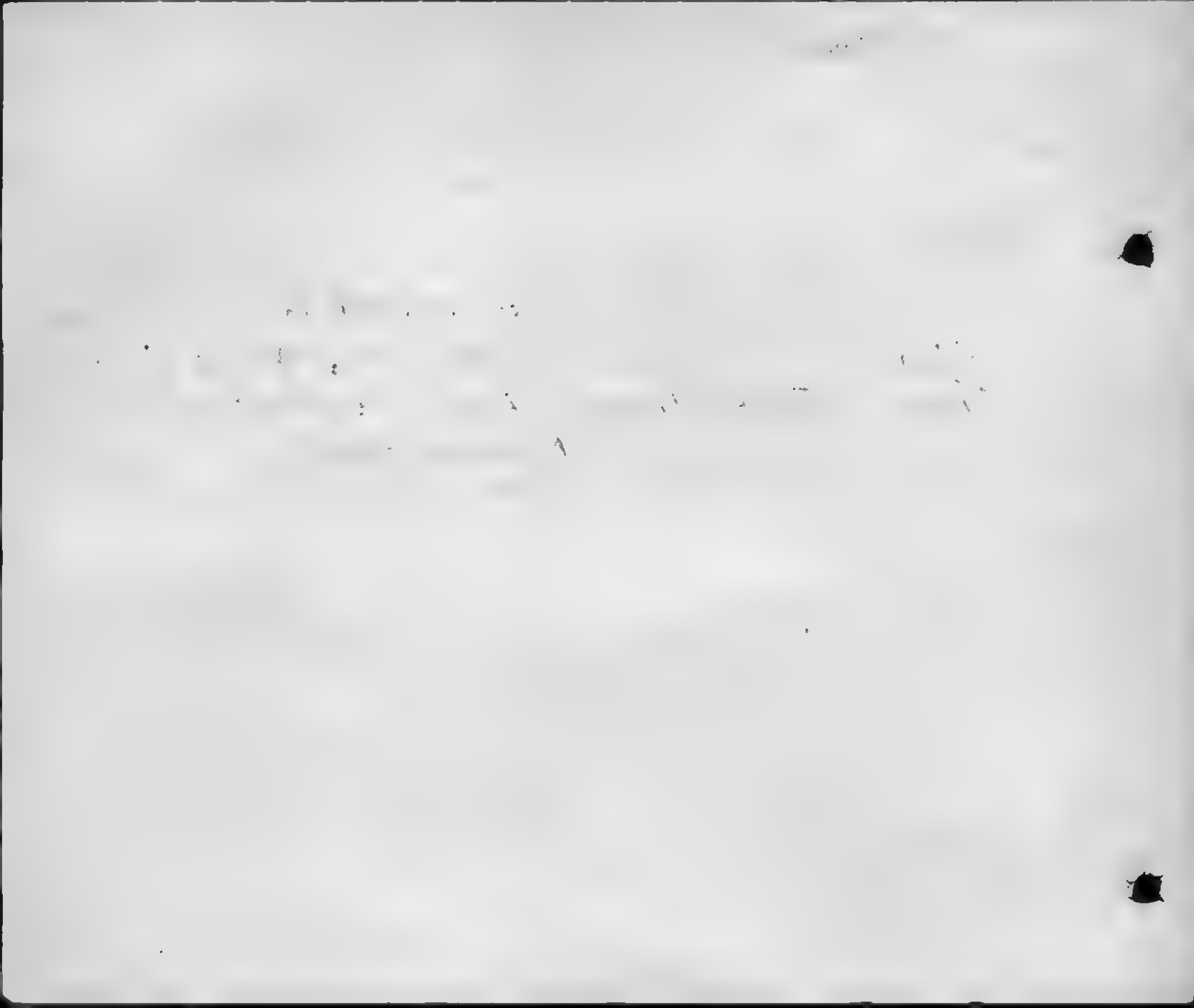
FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11600 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11583

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If instance of Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7400 Flower Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Holly Sharon Huffman</u>		4. DATE OF DEATH <u>October 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 13, 1946</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Dayton Huffman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Augusta Haas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records, Family</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>344.1</u> DUE TO <u>INTERNAL HYDROCEPHALUS, MARKEDLY SEVERE</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause last. DUE TO <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>CEREBRAL PALSY</u> for life		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW D.C.</u>	
REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	
DATE <u>OCT 30 '61</u>		DATE <u>10-27-61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

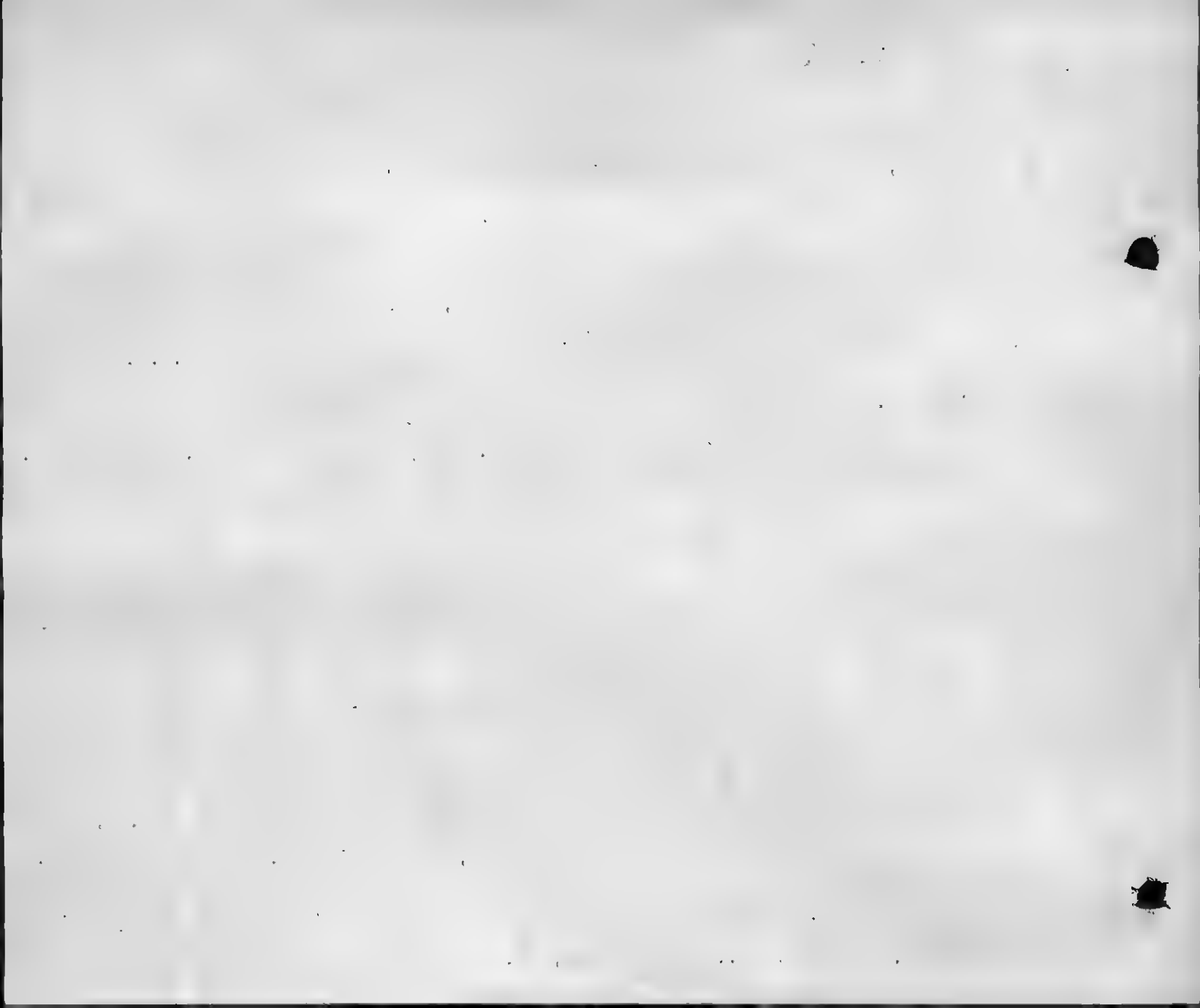
CERTIFICATE OF DEATH

11601

11586

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, SILVER SPRING		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2015 SHOREFIELD ROAD		d. STREET ADDRESS 2015 SHOREFIELD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY CLEVELAND HULL		4. DATE OF DEATH OCTOBER 7 19 61		5. SEX MALE	
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 21, 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN (retired)		10b. KIND OF BUSINESS OR INDUSTRY GOV'T.		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY COUNTY MARYLAND	
13. FATHER'S NAME CHARLES M. HULL		14. MOTHER'S MAIDEN NAME MARGARET ROBERTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 579-20-0427		17. INFORMANT HARRY B. HULL, 4415 ASPEN HILL RD., ROCKVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) coronary + thrombosis (a), stating the underlying cause last. } DUE TO (c) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring, Md.	
20f. (City or town) Silver Spring, Md.		20g. (County) Prince George's County		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1961, to Oct. 7, 1961, that (I) (we) last saw the deceased alive on Oct. 7, 1961, and that death occurred at 10:10 PM, from the causes and on the date stated above.					
22a. SIGNATURE Patrick Jameson M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 9, 1961	
22c. PHYSICIAN'S NAME (Type) PATRICK JAMESON		22d. ADDRESS 12,020 GEORGIA AVE., SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 10, 1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	
23d. LOCATION (City, town or county) PRINCE GEORGE'S COUNTY, MD.		23e. REC'D BY REGISTRAR DATE OCT 10 '61			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zioka		ADDRESS FARNER E. PUMPHREY, INC., SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

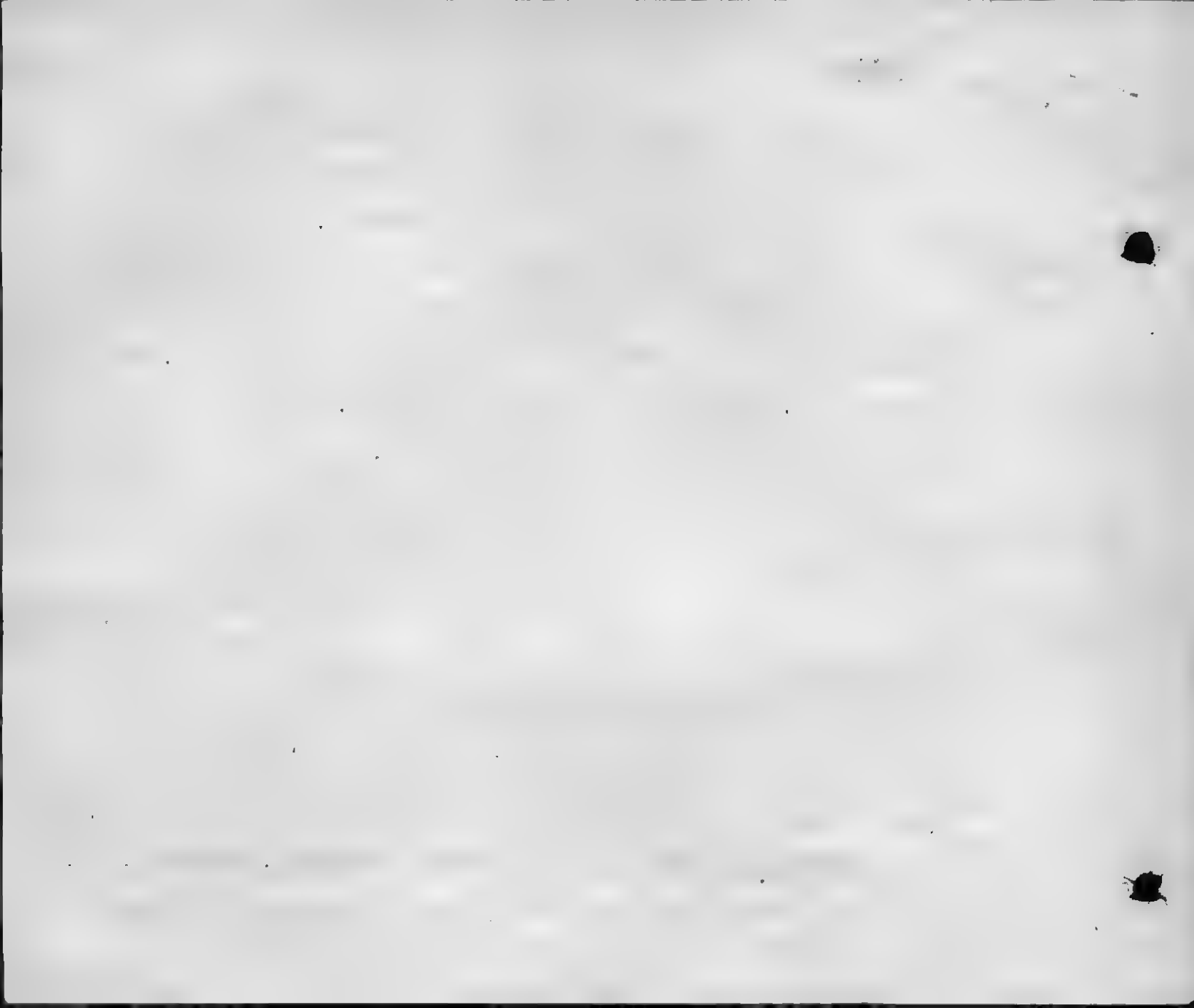
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11602

11587

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN b. <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>6005 WALTON RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLA CHAPPELL HUNDLEY</u> First Middle Last 4. DATE OF DEATH <u>OCT. 16, 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/28/91</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years, last birthday) <u>69</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles B. Chappell</u> 14. MOTHER'S MAIDEN NAME <u>Emma L. Slater</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Daughter Mrs. Blanche Brust</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Bleeding Esophageal VARICES</u> <u>5810</u> DUE TO (b) <u>Cirrhosis, Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>?</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>?</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u> 20f. (City or town) (County) (State) <u>?</u>	
21. I certify that (I) (the funeral director) attended the deceased from July 27, 1950 to Oct. 16, 1961, that (I) (the funeral director) saw the deceased alive on Oct. 16, 1961, and that death occurred at 12:15 PM, from the causes and on the date stated above. 22a. SIGNATURE <u>Robert G. Angle</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22b. DATE SIGNED <u>10/16/61</u> 22d. ADDRESS <u>5009 DelRay Ave. Bethesda, Md.</u> 22e. REC'D BY REGISTRAR <u>Arthur S. Huns</u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 10/20/61</u> 23b. DATE THEREOF <u>10/20/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Mem. Park</u> 23d. LOCATION (City, town or county) (State) <u>Louisville, Kentucky</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>OCT 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11603

CERTIFICATE OF DEATH

11588

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY White Plains	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 North Broadway	
c. LENGTH OF STAY IN 1b 12 days		d. STREET ADDRESS 20 North Broadway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gunther Waldemar Hunter		4. DATE OF DEATH Month October Day 14 Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1903	
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months 58 Days 14 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X-ray Salesman		10b. KIND OF BUSINESS OR INDUSTRY I-Ray	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Hunter Herman Hunter		14. MOTHER'S MAIDEN NAME Else Friedlander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO 087-01-6056	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with carcinomatosis DUE TO (b) Atelectasis of left lung DUE TO (c) Duodenal ulcer CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 2, 1961 to October 14, 1961 that (X) (we) last saw the deceased alive on October 14, 1961 , and that death occurred 8:45AM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 10/14/61	
22c. PHYSICIAN'S NAME (Type) ROBERT H. LEVIN, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Oct. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		25a. REC'D BY REGISTRAR OCT 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. ADDRESS 8434 Ga. Ave Silver Spring Md.	

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CERTIFICATE OF DEATH

Reg. Dist. No.

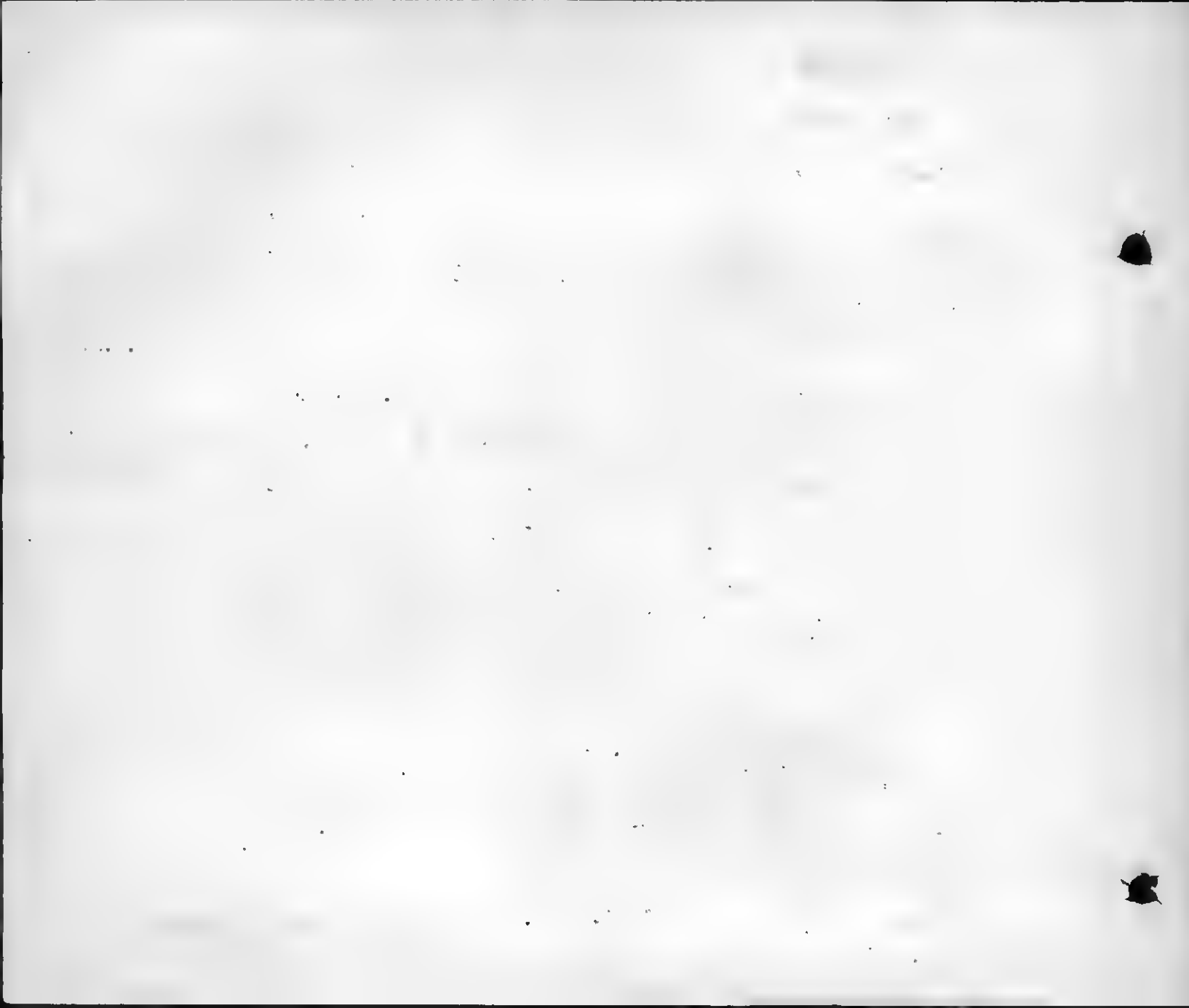
11589

11604

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring, Md				c. LENGTH OF STAY IN 1b 1 yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Hurd				4. DATE OF DEATH Month Day Year Oct 2 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1879	
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-lady				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Daniel Young			
14. MOTHER'S MAIDEN NAME Mary S. Washington				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				INFORMANT Address Mr George E. Shackelford (Same as Item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction (b) Chronic myocardial infarction (c) Myocardial infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Diabetes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 12 1960 , to Oct 2, 1961 , that I last saw the deceased alive on Sept 25, 1961 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED 1819 Seminary Rd Silver Spring Md 10-26							
ACTUAL SIGNATURE [Signature]							
PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/61		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Browder				24. REGISTRATION SIGNATURE Albert S. Kraus			
25. REC'D BY REGISTRAR OCT 10 '61				26. REGISTRAR'S SIGNATURE Albert S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

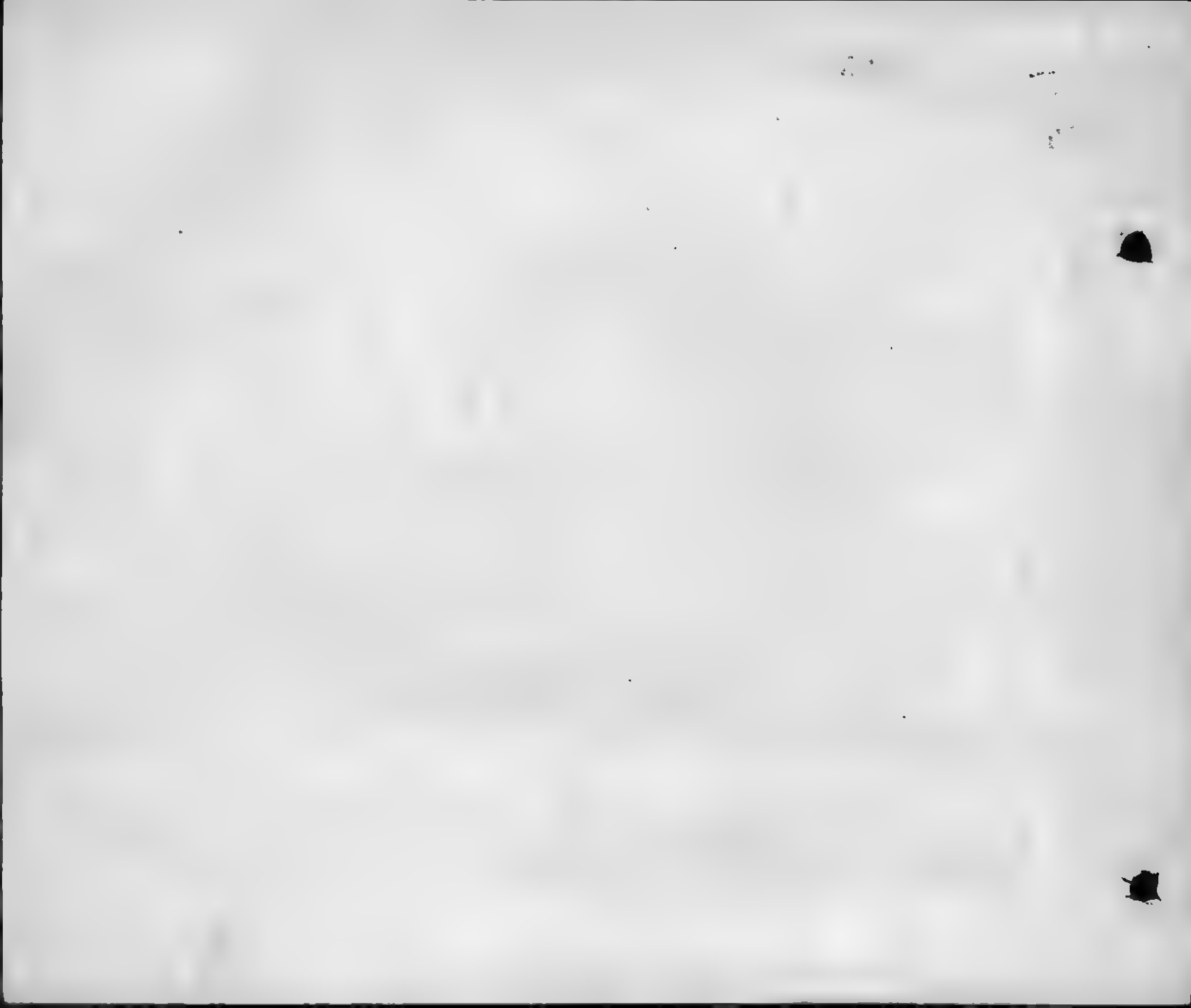
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.
M
DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
11605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>XXXXX</u> b. COUNTY <u>ARLINGTON, VIRGINIA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, Virginia</u> d. STREET ADDRESS <u>111 Arlington Blvd.</u>				3. NAME OF DECEASED (Type or print) <u>Claude Emerson Huson</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>9</u> - Year <u>1961</u>							
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-13-92</u>				9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) <u>69</u> yrs Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mattos Inc.</u>				11. BIRTHPLACE (State or foreign country) <u>N. J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Arthur B. Huson</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Gordon</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Washington Sanitarium & Hosp. Rec.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain lacerations and contusions</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of the skull</u> (a), stating the underlying cause last, (c) <u>A fall</u>												3 $\frac{1}{2}$ months 3 $\frac{1}{2}$ months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Reported fall on floor at home</u>															
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> p.m. <u>6-27</u> 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>				M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				Address (Street, city, town, or county) <u>10-9-61</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>10/11/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				22d. LOCATION (City, town, or country) (State) <u>PP, Geo. Co., Md</u>							
23. FUNERAL DIRECTOR <u>Wm Chambers</u>				ADDRESS <u>1400 Chapin St NW</u>				24a. REC'D BY REGISTRAR <u>OCT 13 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

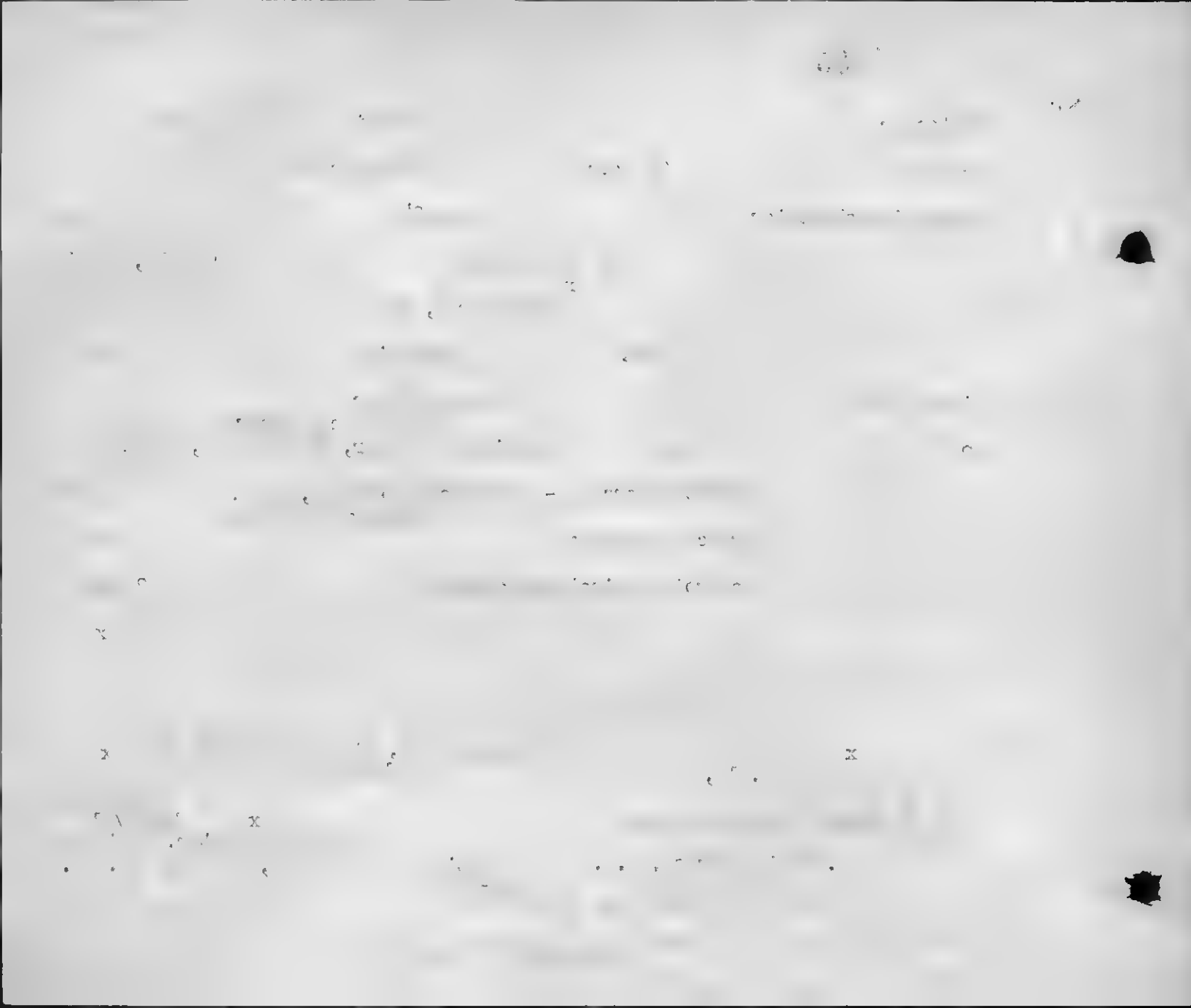
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11606

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 21 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Loudon c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Paeonian Springs d. STREET ADDRESS Box 24 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JERRY LYNN JAMES		4. DATE OF DEATH October 13, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1957	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 3 yrs.		10. BIRTHPLACE (County & State, or foreign country) Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		12. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME William James		14. MOTHER'S MAIDEN NAME Eva Mae Helbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma - metastasis to brain, lungs, kidney and pancreas CONDITIONS, if any, which gave rise to immediate cause (b) Bronchopneumonia causing the underlying cause last. (c) Gastrointestinal hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 16 months 2 weeks 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 22, 1961 to October 13, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 13, 1961 , and that death occurred at 9:13AM from the causes and on the date stated above.			
22a. SIGNATURE J. David Heywood		22b. DATE SIGNED 10/13/61	
22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/15/61	
23c. NAME OF CEMETERY OR CREMATORY Bethel Church		23d. LOCATION (City, town or county) Leesburg, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25. REC'D BY REGISTRAR 10/16/61	
25a. ADDRESS 1400 Chapin St. N.W. Wash. D.C.		25b. REGISTRAR'S SIGNATURE Clifford S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11607

CERTIFICATE OF DEATH

11592

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY in 1b 1 week		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 609 Deerfield Avenue S.S. Md.		e. STREET ADDRESS 609 Deerfield Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA		First IDA Middle EVA Last JOHNSON		4. DATE OF DEATH Month October Day 6 Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5/15/1877	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE County & State, or foreign country Finland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Tiittinen		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Herbert F. Hathaway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 450 DUE TO Cardiac Disturbance Acute Pneumonia Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 weeks 5-6 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): None		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None			
21c. TIME OF INJURY Month, Day, Year 19		21d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
21f. (City or town) Silver Spring		21g. (County) Montgomery		21h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Oct 5, 1961, to Oct 6, 1961, that (I) (we) last saw the deceased alive on Oct 5, 1961, and that death occurred at 7:20 AM, from the causes and on the date stated above.					
22a. SIGNATURE W. B. Wardrop, M.D.		22b. PHYSICIAN'S NAME (Type) W. B. Wardrop, M.D.		22c. ADDRESS 609 Deerfield Avenue, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION (City, town or county) Prince George Co Md.		23e. REC'D BY REGISTRAR ACT 10 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1971

1

2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000



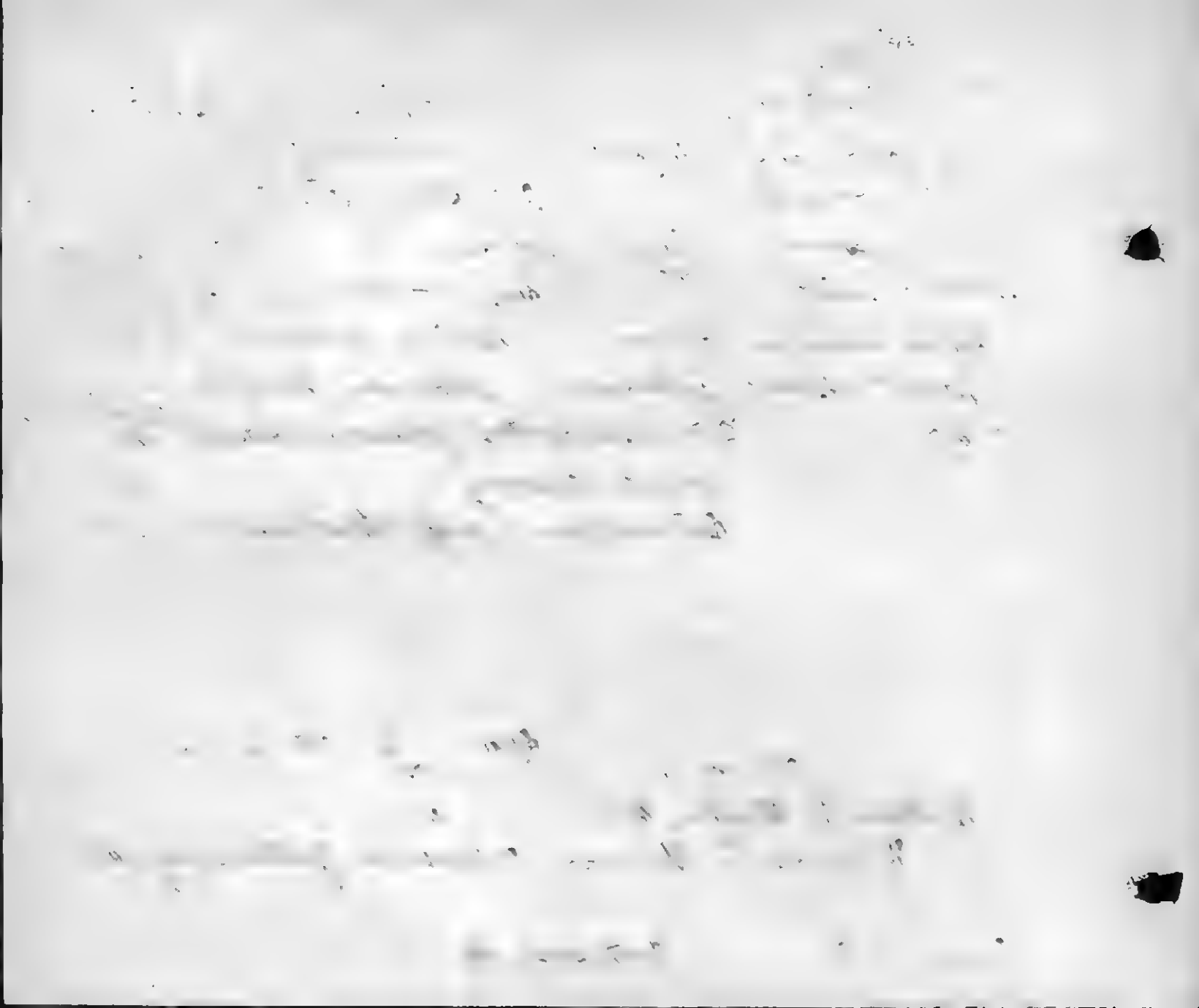
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11608

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11593

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
c. LENGTH OF STAY IN 1b <i>4 years</i>		d. STREET ADDRESS <i>607 Alden Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Edgar</i> Last <i>Johnson</i>		4 DATE OF DEATH Month <i>Oct</i> Day <i>26</i> Year <i>1961</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Aug-13-1885</i>
9 AGE (In years last birthday) <i>76</i> yrs.		10 IF UNDER 1 YEAR Months <i>2</i> Days <i>13</i> Hours <i>—</i> Min. <i>—</i>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farm manager</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11 BIRTHPLACE (State or foreign country) <i>Marion Indiana</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>Jacob Isaac Johnson</i>		14 MOTHER'S MAIDEN NAME <i>Rebecca Nicholson</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16 SOCIAL SECURITY NO <i>218-07-6563</i>	
17 INFORMANT <i>Worthing E. Johnson</i>		Address <i>607 Alden St., Gaithersburg, Md.</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary</i> DUE TO <i>Anteroseclerosis, high arterial tension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> (c) <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>9 hours</i> <i>6 mo.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i>—</i>		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April - 1961</i> to <i>Oct-26-1961</i> , that (I) (we) last saw the deceased alive on <i>Oct-26-1961</i> , and that death occurred at <i>9 P M</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>William C. Miller, M.D.</i>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d ADDRESS <i>7 Brook Ave., Gaithersburg, Md.</i>	
23a. BURIAL, CREMATION, REINTERMENT, (Specify)		23b. DATE THEREOF <i>10-22-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		23d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Ernest Gartner</i>		25a. REGISTRAR'S SIGNATURE <i>William S. Hance</i>	
ADDRESS <i>Gaithersburg, Md.</i>		25b. REGISTRAR'S SIGNATURE	



11609

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

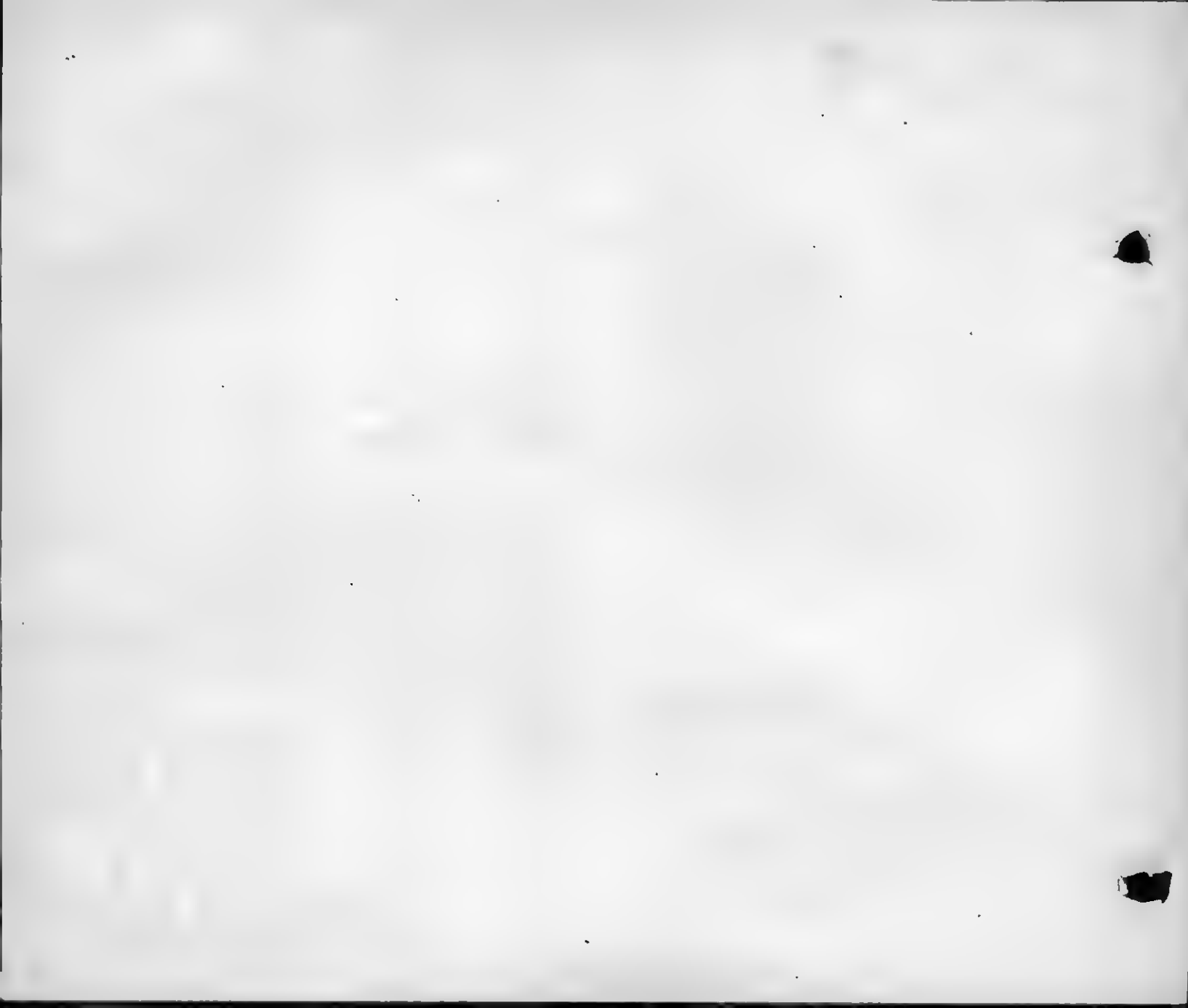
CERTIFICATE OF DEATH

11594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marble Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>B</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH <u>Oct</u> Month <u>19</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 1873</u>	
9. AGE (In years lost birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. U.S.A. OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Saleswoman (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Sales</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington County, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Jefferson G. Perren</u>				14. MOTHER'S MAIDEN NAME <u>Jennie H. Bokes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Dorothy F. Decker, (same as #2)</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u> <u>10 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>56</u> to <u>19 Oct</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12 Oct</u> 19 <u>61</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M B Queen</u>				22b. DATE SIGNED <u>19 Oct 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>M B QUEEN</u>				22d. ADDRESS <u>7112 Yellow Pine Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 23, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Neversburg, West Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>OCT 23 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>				25c. ADDRESS <u>254 Carroll St. N.W. Wash. D.C.</u>			

(M)

(I)



within 24 hours after

SPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral

director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should

be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

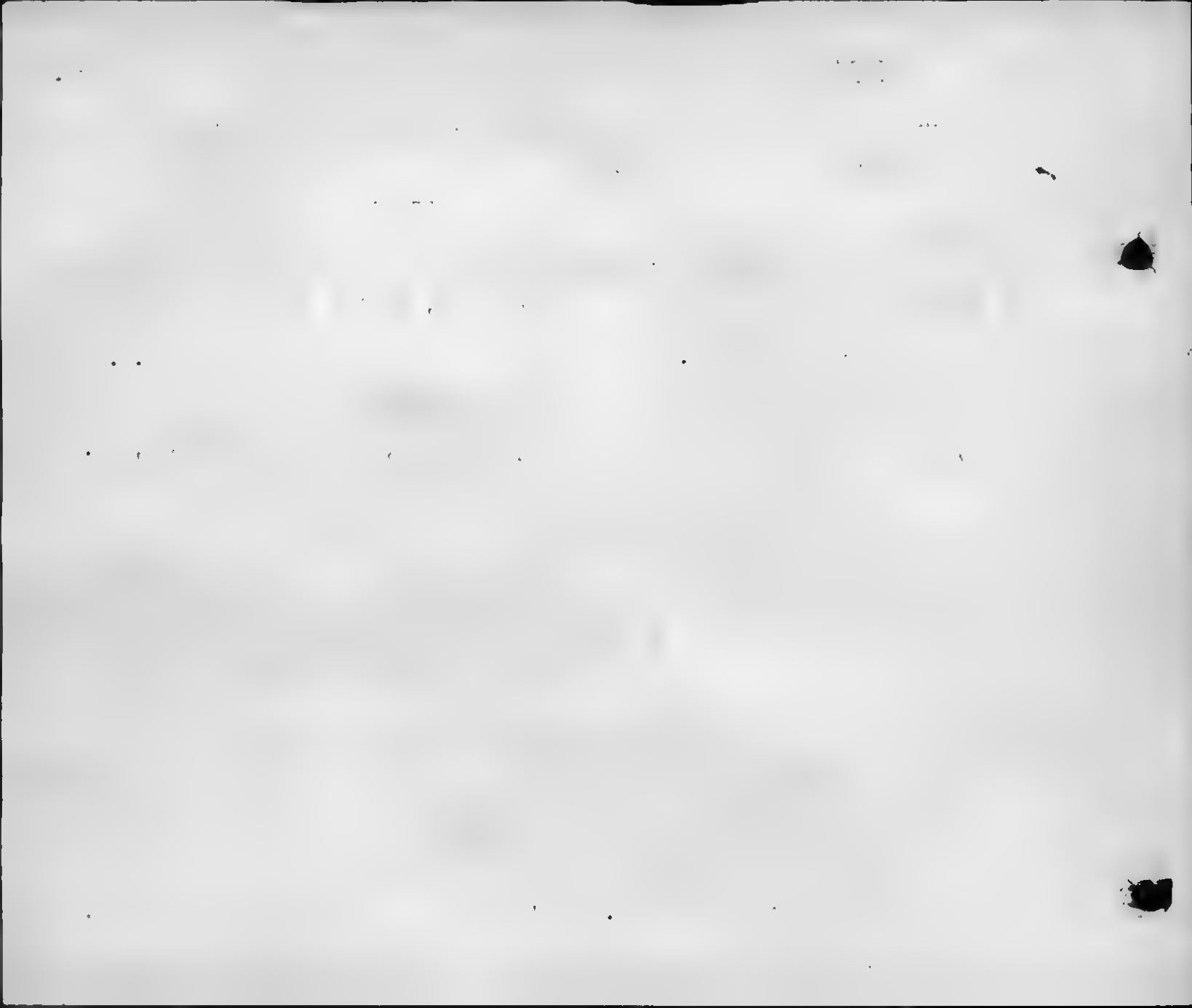
CERTIFICATE OF DEATH

11610

Item Id, Film 5297 10/11/61 iwk

11595

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Private home, Crocus Drive		d. STREET ADDRESS Dickerson	
3. NAME OF DECEASED (Type or print) First Middle Last Reginald Bernard Jones		4. DATE OF DEATH Month Day Year 10 1 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days 10 1 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural mail carrier		10b. KIND OF BUSINESS OR INDUSTRY Gov. mail carrier	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Henry Jones		14. MOTHER'S MAIDEN NAME Ella Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT C. Robert Jones	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 152.1 CEREBRAL EMBOLUS Conditions, if any, which gave rise to immediate cause (b) GENERALIZED METASTATIC (c), stating the underlying cause last. BREAST CARCINOMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) CONGESTIVE HEART FAILURE			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Dickerson, Md.	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 20, 1961 to OCT. 2, 1961 , that (I) (we) last saw the deceased alive on 29 SEPT. 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger		22b. DATE SIGNED 10/11/61	
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22d. ADDRESS 310 W. MONTGOMERY DR. ROCKVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town or county) (State) Barnesville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Helton, Barnesville, MD		25a. REC'D BY REGISTRAR OCT 5 '61	
25b. REGISTRAR'S SIGNATURE Gordon S. Rosenberger			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11611

11597

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 15 MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakhaven - 517 Albany Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Dist. of Col. b. COUNTY (D.C.) Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17x d. STREET ADDRESS 5530 Chillum Pl. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isadore First Middle Last 4. DATE OF DEATH Katzman Month Day Year 10 20 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 18 - 1888 9. AGE (In years last birth day) 73 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor 11. BIRTHPLACE (County & State, or foreign country) Kiev, Russia 12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Bernard Katzman 14. MOTHER'S MARDEN NAME Ida 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 219-32-0357 17. INFORMANT Ida Rosenheim (daughter) Address 816 Malter Lane Silver Spring Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROTIC DISEASE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) CARDIO-VASCULAR REAL DISEASE (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GOUT @ DIABETES MELLITUS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1949 to 10-20-61 , that (I) (we) last saw the deceased alive on 10-19-1961 , and that death occurred at 12:30 AM , from the causes and on the date stated above.		22a. SIGNATURE Samuel A. Hillman M.D. 22b. DATE SIGNED 10-20-61 22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN 22d. ADDRESS 8829 - FLOWER AVE. SILVER SPRING	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 10/21/61 23c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM Cem. 23d. LOCATION (City, town or county) (State) Wash. DC		25a. REC'D BY REGISTRAR OCT 23 '61 25b. REGISTRAR'S SIGNATURE ...	

Montgomery

1860-1861

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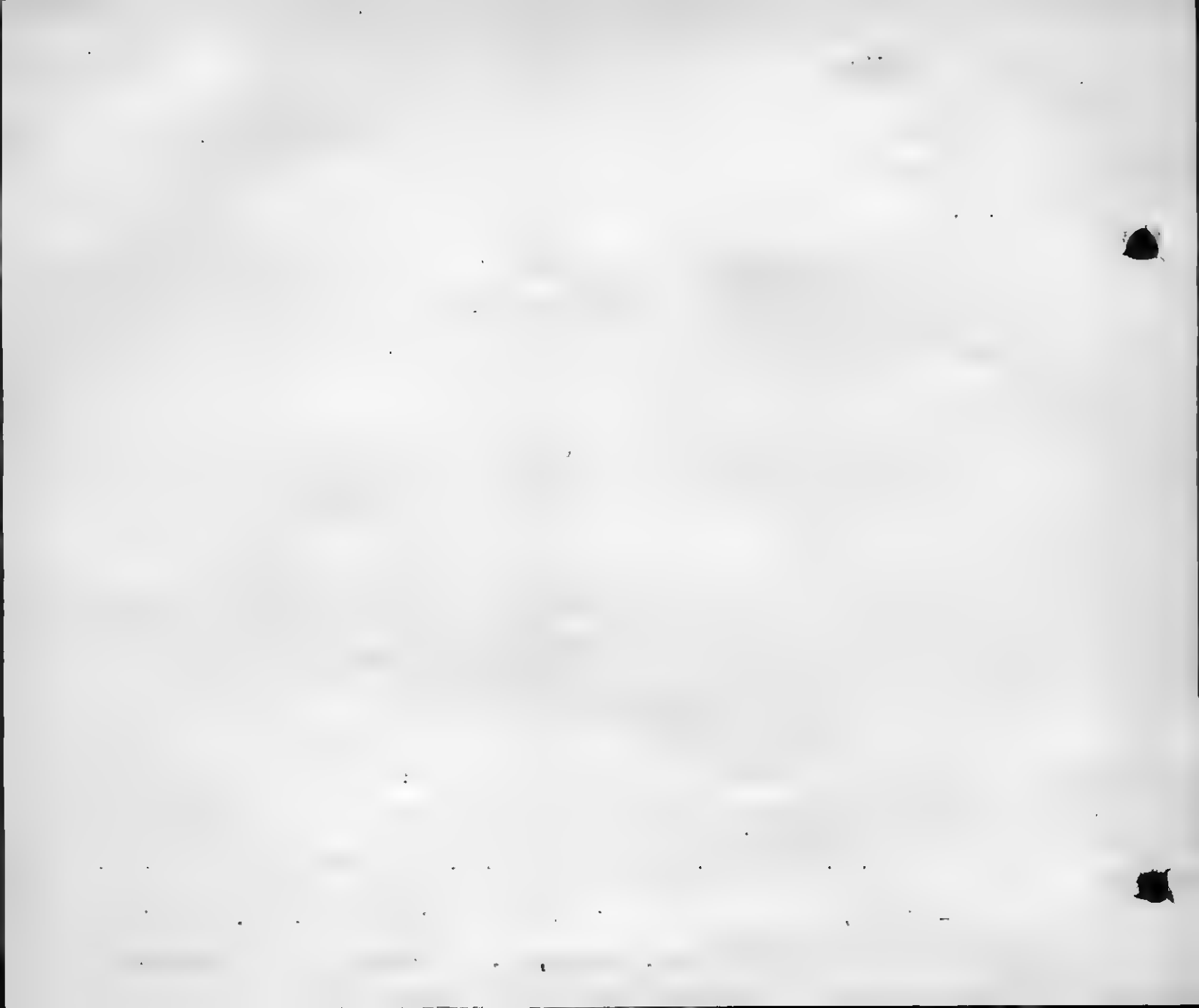
1860-1861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11612
11598
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN IL 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia		b. COUNTY Sutton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH October 1 1961		g. AGE (In years last birthday) 4 yrs. 17 months		h. IF UNDER 1 YEAR Months Days Hours Min.	
3. NAME OF DECEASED (Type or print) Irene Pearl Keener		4. SEX Female		5. COLOR OR RACE Caucasian		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH May 15, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) France		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Dewey Keener		14. MOTHER'S MAIDEN NAME Emma Jean Rose		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT (Mother) Emma Jean Keener, Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 3 4 5 DUE TO Congenital Heart Disease		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Post-operative block procedure		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town Sutton		20g. County W. Virginia		20h. State West Virginia		20i. City or town Sutton		20j. County W. Virginia	
20k. State West Virginia		20l. City or town Sutton		20m. County W. Virginia		20n. State West Virginia		20o. City or town Sutton	
20p. County W. Virginia		20q. State West Virginia		20r. City or town Sutton		20s. County W. Virginia		20t. State West Virginia	
20u. City or town Sutton		20v. County W. Virginia		20w. State West Virginia		20x. City or town Sutton		20y. County W. Virginia	
20z. State West Virginia		20aa. City or town Sutton		20ab. County W. Virginia		20ac. State West Virginia		20ad. City or town Sutton	
20ae. County W. Virginia		20af. State West Virginia		20ag. City or town Sutton		20ah. County W. Virginia		20ai. State West Virginia	
20aj. City or town Sutton		20ak. County W. Virginia		20al. State West Virginia		20am. City or town Sutton		20an. County W. Virginia	
20ao. State West Virginia		20ap. City or town Sutton		20aq. County W. Virginia		20ar. State West Virginia		20as. City or town Sutton	
20at. County W. Virginia		20au. State West Virginia		20av. City or town Sutton		20aw. County W. Virginia		20ax. State West Virginia	
20ay. City or town Sutton		20az. County W. Virginia		20ba. State West Virginia		20bb. City or town Sutton		20bc. County W. Virginia	
20bd. State West Virginia		20be. City or town Sutton		20bf. County W. Virginia		20bg. State West Virginia		20bh. City or town Sutton	
20bi. County W. Virginia		20bj. State West Virginia		20bk. City or town Sutton		20bl. County W. Virginia		20bm. State West Virginia	
20bn. City or town Sutton		20bo. County W. Virginia		20bp. State West Virginia		20bq. City or town Sutton		20br. County W. Virginia	
20bs. State West Virginia		20bt. City or town Sutton		20bu. County W. Virginia		20bv. State West Virginia		20bw. City or town Sutton	
20bx. County W. Virginia		20by. State West Virginia		20bz. City or town Sutton		20ca. County W. Virginia		20cb. State West Virginia	
20cc. City or town Sutton		20cd. County W. Virginia		20ce. State West Virginia		20cf. City or town Sutton		20cg. County W. Virginia	
20ch. State West Virginia		20ci. City or town Sutton		20cj. County W. Virginia		20ck. State West Virginia		20cl. City or town Sutton	
20cm. County W. Virginia		20cn. State West Virginia		20co. City or town Sutton		20cp. County W. Virginia		20cq. State West Virginia	
20cr. City or town Sutton		20cs. County W. Virginia		20ct. State West Virginia		20cu. City or town Sutton		20cv. County W. Virginia	
20cw. State West Virginia		20cx. City or town Sutton		20cy. County W. Virginia		20cz. State West Virginia		20da. City or town Sutton	
20db. County W. Virginia		20dc. State West Virginia		20dd. City or town Sutton		20de. County W. Virginia		20df. State West Virginia	
20dg. City or town Sutton		20dh. County W. Virginia		20di. State West Virginia		20dj. City or town Sutton		20dk. County W. Virginia	
20dl. State West Virginia		20dm. City or town Sutton		20dn. County W. Virginia		20do. State West Virginia		20dp. City or town Sutton	
20dq. County W. Virginia		20dr. State West Virginia		20ds. City or town Sutton		20dt. County W. Virginia		20du. State West Virginia	
20dv. City or town Sutton		20dw. County W. Virginia		20dx. State West Virginia		20dy. City or town Sutton		20dz. County W. Virginia	
20ea. State West Virginia		20eb. City or town Sutton		20ec. County W. Virginia		20ed. State West Virginia		20ee. City or town Sutton	
20ef. County W. Virginia		20eg. State West Virginia		20eh. City or town Sutton		20ei. County W. Virginia		20ej. State West Virginia	
20ek. City or town Sutton		20el. County W. Virginia		20em. State West Virginia		20en. City or town Sutton		20eo. County W. Virginia	
20ep. State West Virginia		20eq. City or town Sutton		20er. County W. Virginia		20es. State West Virginia		20et. City or town Sutton	
20eu. County W. Virginia		20ev. State West Virginia		20ew. City or town Sutton		20ex. County W. Virginia		20ey. State West Virginia	
20ez. City or town Sutton		20fa. County W. Virginia		20fb. State West Virginia		20fc. City or town Sutton		20fd. County W. Virginia	
20fe. State West Virginia		20ff. City or town Sutton		20fg. County W. Virginia		20fh. State West Virginia		20fi. City or town Sutton	
20fj. County W. Virginia		20fk. State West Virginia		20fl. City or town Sutton		20fm. County W. Virginia		20fn. State West Virginia	
20fo. City or town Sutton		20fp. County W. Virginia		20fq. State West Virginia		20fr. City or town Sutton		20fs. County W. Virginia	
20ft. State West Virginia		20fu. City or town Sutton		20fv. County W. Virginia		20fw. State West Virginia		20fx. City or town Sutton	
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20fp. State West Virginia		20fq. City or town Sutton		20fr. County W. Virginia		20fs. State West Virginia		20ft. City or town Sutton	
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20fz. City or town Sutton		20ga. County W. Virginia		20gb. State West Virginia		20gc. City or town Sutton		20gd. County W. Virginia	
20ge. State West Virginia		20gf. City or town Sutton		20gg. County W. Virginia		20gh. State West Virginia		20gi. City or town Sutton	
20gj. County W. Virginia		20gh. State West Virginia		20gi. City or town Sutton		20gj. County W. Virginia		20gk. State West Virginia	
20gl. City or town Sutton		20gm. County W. Virginia		20gn. State West Virginia		20go. City or town Sutton		20gp. County W. Virginia	
20gq. State West Virginia		20gr. City or town Sutton		20gs. County W. Virginia		20gt. State West Virginia		20gu. City or town Sutton	
20gv. County W. Virginia		20gw. State West Virginia		20gx. City or town Sutton		20gy. County W. Virginia		20gz. State West Virginia	
20ha. City or town Sutton		20hb. County W. Virginia		20hc. State West Virginia		20hd. City or town Sutton		20he. County W. Virginia	
20hf. State West Virginia		20hg. City or town Sutton		20hh. County W. Virginia		20hi. State West Virginia		20hj. City or town Sutton	
20hk. County W. Virginia		20hl. State West Virginia		20hm. City or town Sutton		20hn. County W. Virginia		20ho. State West Virginia	
20hp. City or town Sutton		20hq. County W. Virginia		20hr. State West Virginia		20hs. City or town Sutton		20ht. County W. Virginia	
20hu. State West Virginia		20hv. City or town Sutton		20hw. County W. Virginia		20hx. State West Virginia		20hy. City or town Sutton	
20hz. County W. Virginia		20ia. State West Virginia		20ib. City or town Sutton		20ic. County W. Virginia		20id. State West Virginia	
20ie. City or town Sutton		20if. County W. Virginia		20ig. State West Virginia		20ih. City or town Sutton		20ii. County W. Virginia	
20ij. State West Virginia		20ik. City or town Sutton		20il. County W. Virginia		20im. State West Virginia		20in. City or town Sutton	
20io. County W. Virginia		20ip. State West Virginia		20iq. City or town Sutton		20ir. County W. Virginia		20is. State West Virginia	
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20jj. City or town Sutton		20jk. County W. Virginia		20jl. State West Virginia		20jm. City or town Sutton		20jn. County W. Virginia	
20jo. State West Virginia		20jp. City or town Sutton		20jq. County W. Virginia		20jr. State West Virginia		20js. City or town Sutton	
20jt. County W. Virginia		20ju. State West Virginia		20jv. City or town Sutton		20jw. County W. Virginia		20jx. State West Virginia	
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20kd. State West Virginia		20ke. City or town Sutton		20kf. County W. Virginia		20kg. State West Virginia		20kh. City or town Sutton	
20ki. County W. Virginia		20kl. State West Virginia		20km. City or town Sutton		20kn. County W. Virginia		20ko. State West Virginia	
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20ln. County W. Virginia		20lj. State West Virginia		20lk. City or town Sutton		20ll. County W.			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11613

11593

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY N 1b <u>10,515 Cascade Place</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LeDeau Gardens Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10,515 Cascade Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1881</u> 9. AGE (In years, last birthday) <u>80</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Mrs. Cavet C. Snyder</u>		Address <u>10,515 Cascade Place Silver Spring, Md.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis Syndrome</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/27/61</u> , 19 <u>61</u> , to <u>10/21/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/21/61</u> , 19 <u>61</u> , and that death occurred at <u>10/21/61</u> , M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John David Herman</u> M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 22b. DATE SIGNED <u>Nov 1, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 11/6/61</u>		23b. DATE THEREOF <u>11/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u> <u>434 Georgia Avenue</u> <u>Arner E. Humphrey, Inc.</u>		23d. LOCATION (City, town or county) (State) <u>Spearfish, South Dakota</u>	
24. REC'D BY REGISTRAR <u>NOV 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

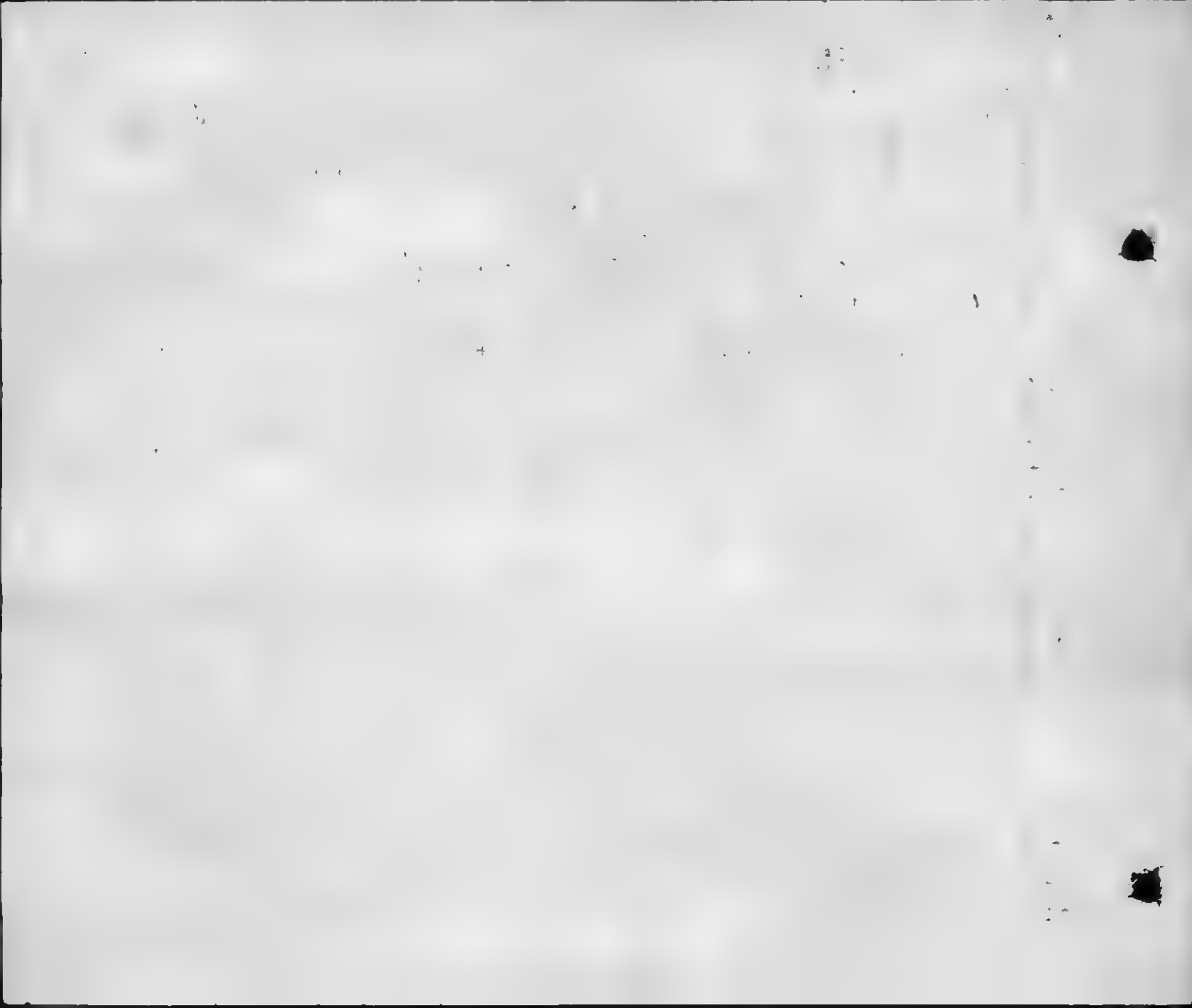
CERTIFICATE OF DEATH

11614

11600

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>8613 Piney Branch Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond</u> First Middle Last 4. DATE OF DEATH <u>10 15 1961</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-28-86</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt.</u> 13. FATHER'S NAME <u>Kyle, John T.</u>		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Country & State, or foreign country) <u>D.C.</u> 14. MOTHER'S MAIDEN NAME <u>Hellen Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>579-16-0308</u> 17. INFORMANT <u>Pt. chart.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 500X DUE TO (b) <u>Acute Bronchitis</u> (c) <u>Bacterial Infection</u> : <u>Pseudomonas Aer. and E. Coli</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Emphysema</u> <u>Constrictive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u> <u>10 Days</u> <u>10 Days</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 14, 1961</u> to <u>October 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 15, 1961</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Stuart L. Nelson</u> 22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u>		22b. DATE SIGNED <u>10/15/61</u> 22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> 3821-14th St. NW Wash. D.C.		25a. REC'D BY REGISTRAR <u>ACT 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

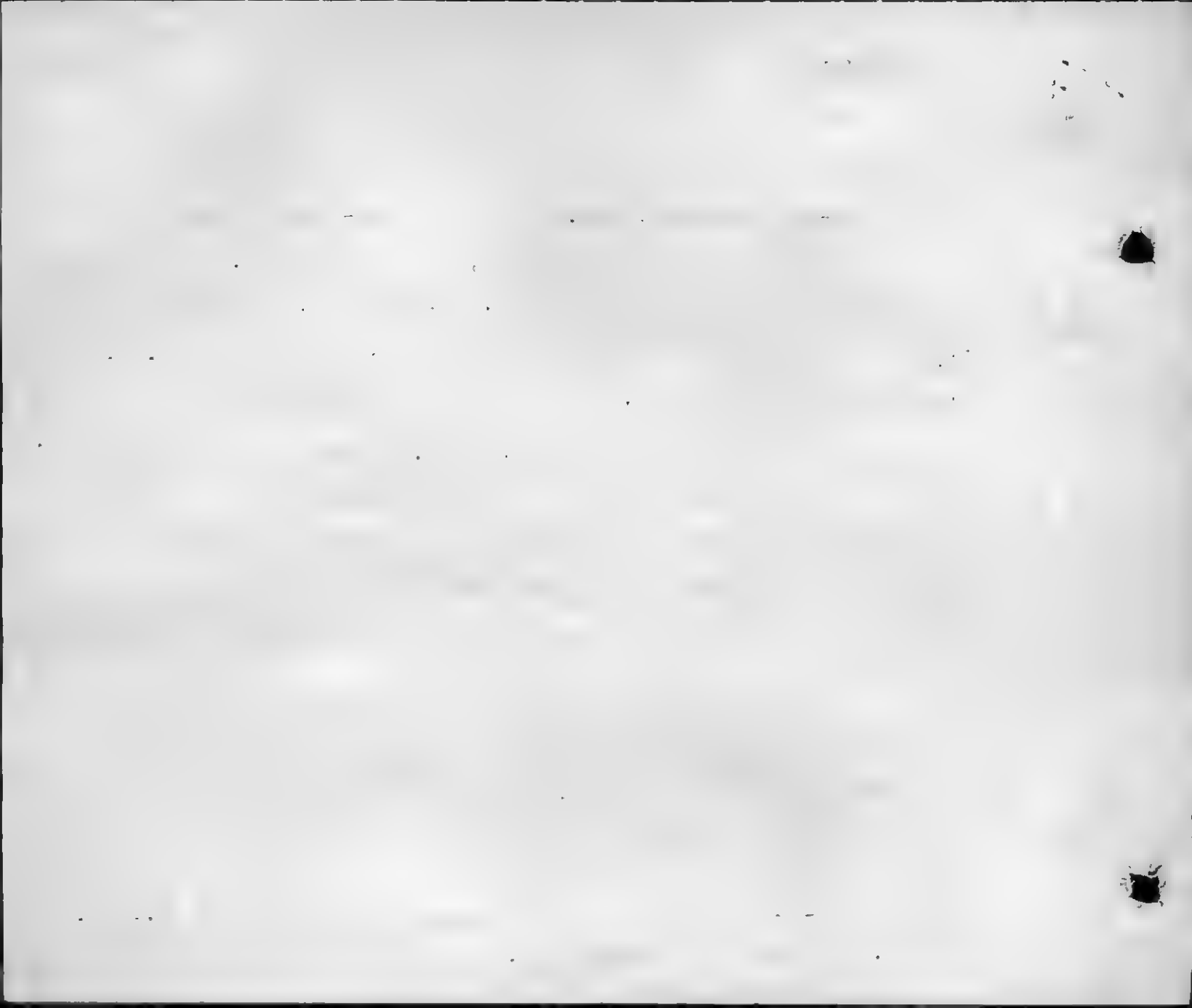
CERTIFICATE OF DEATH

11616

11602

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN It MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4405 East-West Highway, Apt. 602		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4405 East-West Highway	
3. NAME OF DECEASED (Type or print) ESPER SIGNIUS LARSEN, III 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE DEATH Oct. 6, 1961 8. DATE OF BIRTH Oct. 10, 1912 9. AGE (in years last birthday) 48 yrs. 11 months 26 days IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist 13. FATHER'S NAME Esper Signius Larsen, Jr.		11. BIRTHPLACE (County & State, or foreign country) California 12. CITIZEN OF WHAT COUNTRY? U. S. 14. MOTHER'S MAIDEN NAME Eva Audrey Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Wife Marjorie A. Larsen Address Same as Item 2.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial Infarction DUE TO Coronary Thromboses + Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertensive Arteriosclerotic Heart Disease DUE TO 13 + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Paraplegia, 37 yrs. due to injury in childhood	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that, (I) (this hospital) attended the deceased from May, 1950 to present, 1961 that (I) (we) last saw the deceased alive on 10/4, 1961 and that death occurred at 7:57 AM from the causes and on the date stated above.			
22a. SIGNATURE Francis J. Murray 22c. PHYSICIAN'S NAME (Type) FRANCIS J. MURRAY MD		22b. DATE SIGNED 10/6/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 2111 Bancroft Pl NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 10-7-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION (City, town or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. RECEIVED BY REGISTRAR Oct 13 61 25b. REGISTRAR'S SIGNATURE Robert S. Frame	

SPECIAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



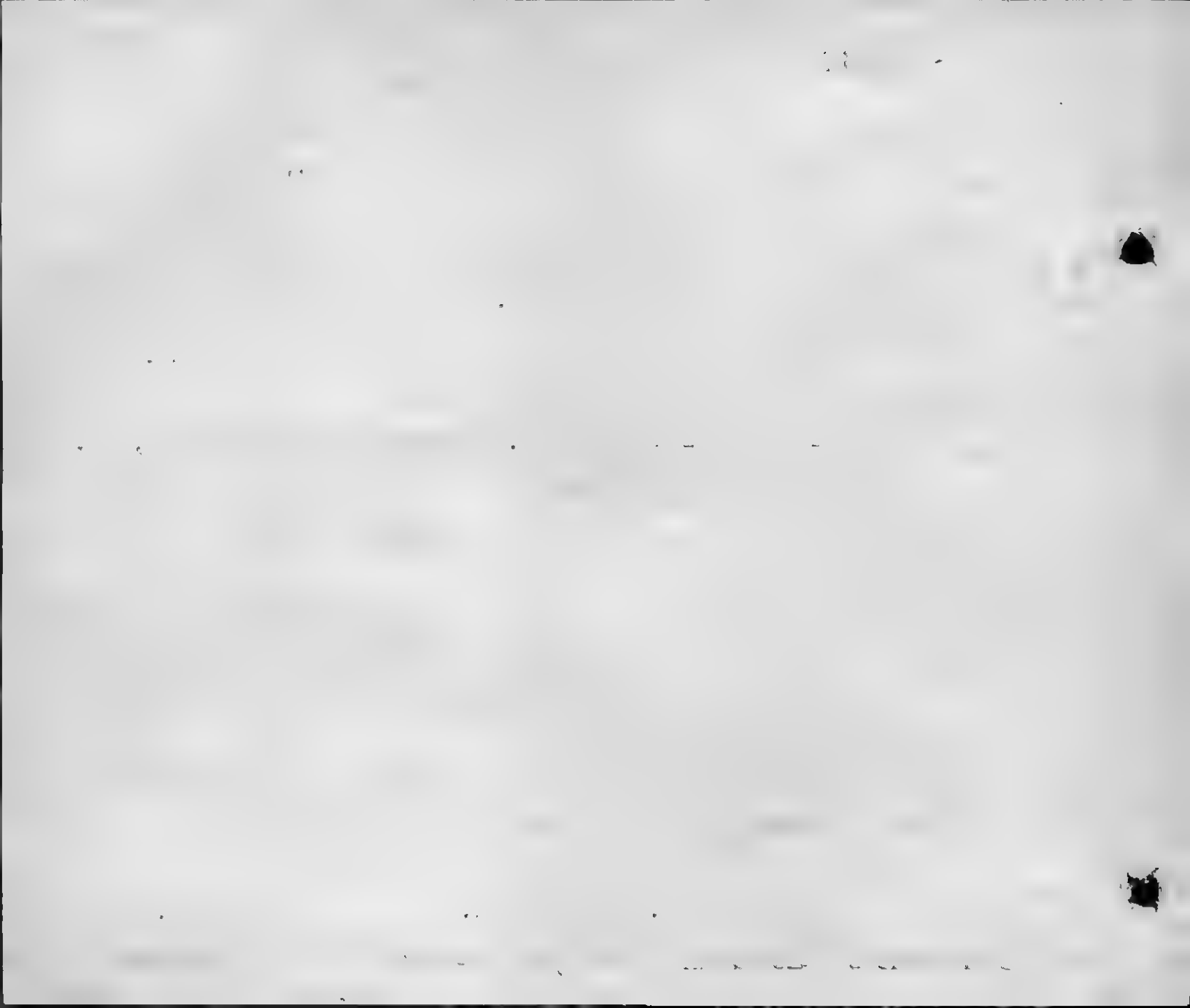
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A11 (4)
15M 9/60

B.D.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11617											
Items 1 & 2 Fill in											
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2001 Bel Pre Rd.				c. LENGTH OF STAY IN IT 26 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Silver Spring, Md.				e. STATE Maryland				f. COUNTY Montgomery			
3. NAME OF DECEASED (Type or print) Alick				First Middle Last Leibovitz				4. DATE OF DEATH 10 26 19 61			
5. SEX Male		6. COLOR OR RACE Hebrew		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1883		9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Clothing				11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 346-01-2346				17. INFORMANT Mrs. Roberta Leib 6306 Crathie Lane, D.C.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Carcinoma of right kidney Carcinoma of right kidney			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) Hyattsville, Md.				20g. (County) Montgomery							
21. I certify that (I) (this hospital) attended the deceased from June 1961, to Oct 1961, that (I) (we) last saw the deceased alive on 10/15/1961, and that death occurred at 2:15 PM, from the causes and on the date stated above.											
22a. SIGNATURE Maurice Franks				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) Maurice Franks, M.D.			
22d. ADDRESS 901 20th St NW, Wash 6, D.C.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF Oct 27, 1961				23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cem.				23d. LOCATION (City, town or county) Hyattsville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Franks				24b. ADDRESS 4217-9th St NW				25a. REC'D BY REGISTRAR DATE OCT 30 '61			
25b. REGISTRAR'S SIGNATURE											



TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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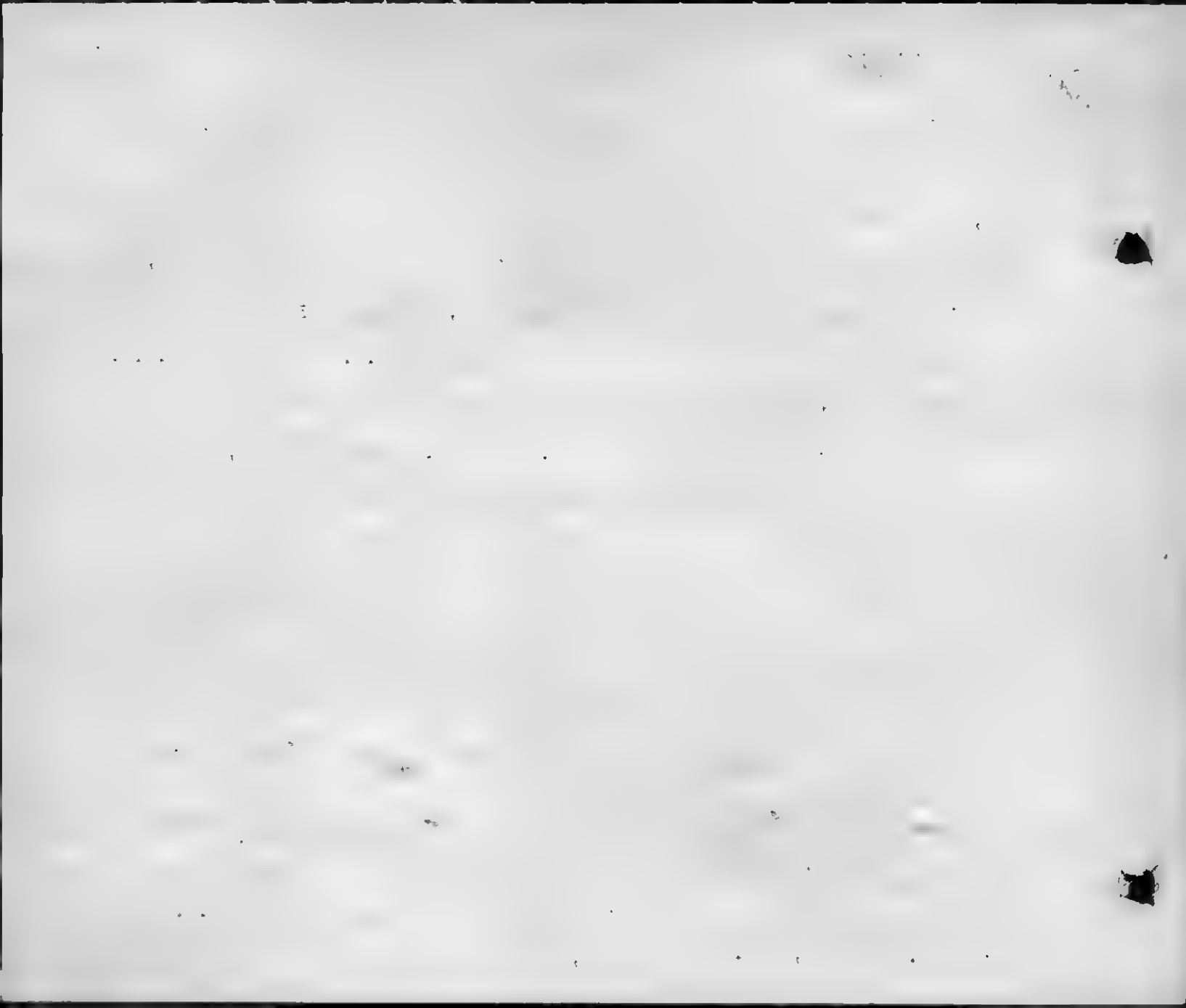
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11604

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 4003 Blackpool Road	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Marilea Nursing Home	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 511 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Henrietta Leins		4. DATE OF DEATH October 3, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1878	
9. AGE (in years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry W. Sievers	
14. MOTHER'S MAIDEN NAME Elizabeth Trusheim		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Robert W. Leins Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181. ci DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		INTERVAL BETWEEN ONSET AND DEATH Concussion of Brainy Blood	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1961 to Oct 3, 1961 , that (I) (we) last saw the deceased alive on Oct 2, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John S. Rogers 22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22b. DATE SIGNED Oct 4, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Oct 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11619 CERTIFICATE OF DEATH 11605

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12201 Glen Mill Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 12201 Glen Mill Road	
3. NAME OF DECEASED (Type or print) Elizabeth R Lepley 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH March 4, 1889 8. AGE (In years last birthday) 72 yrs 9. IF UNDER 1 YEAR: Months 7 Days 9 Hours 13 Min. 19 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. PLACE (County & State, or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Reilly Own Home Ohio USA Rose Mapes		14. MOTHER'S MAIDEN NAME Rose Mapes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE Myocardial Failure (b) Coronary arteriosclerosis (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Cerebral arteriosclerosis; CVA - 4/20/60	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 4201 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Washington, D.C.	
21. I certify that (I) (this hospital) attended the deceased from 1959, to Oct. 13, 1961, that (I) (we) last saw the deceased alive on Oct. 12, 1961, and that death occurred at 1:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Curtin M.D. 22b. DATE SIGNED Oct. 16 '61		22c. PHYSICIAN'S NAME (Type) Thomas E. Curtin 22d. ADDRESS 4600 Connecticut Ave. N.W. Wash. D.C.	
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial 23c. DATE THEREOF 10/16/61 23d. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23e. LOCATION (City, town or county) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. ADDRESS 317 Pa. Ave., SE		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles S. Kraus DATE OCT 16 '61	



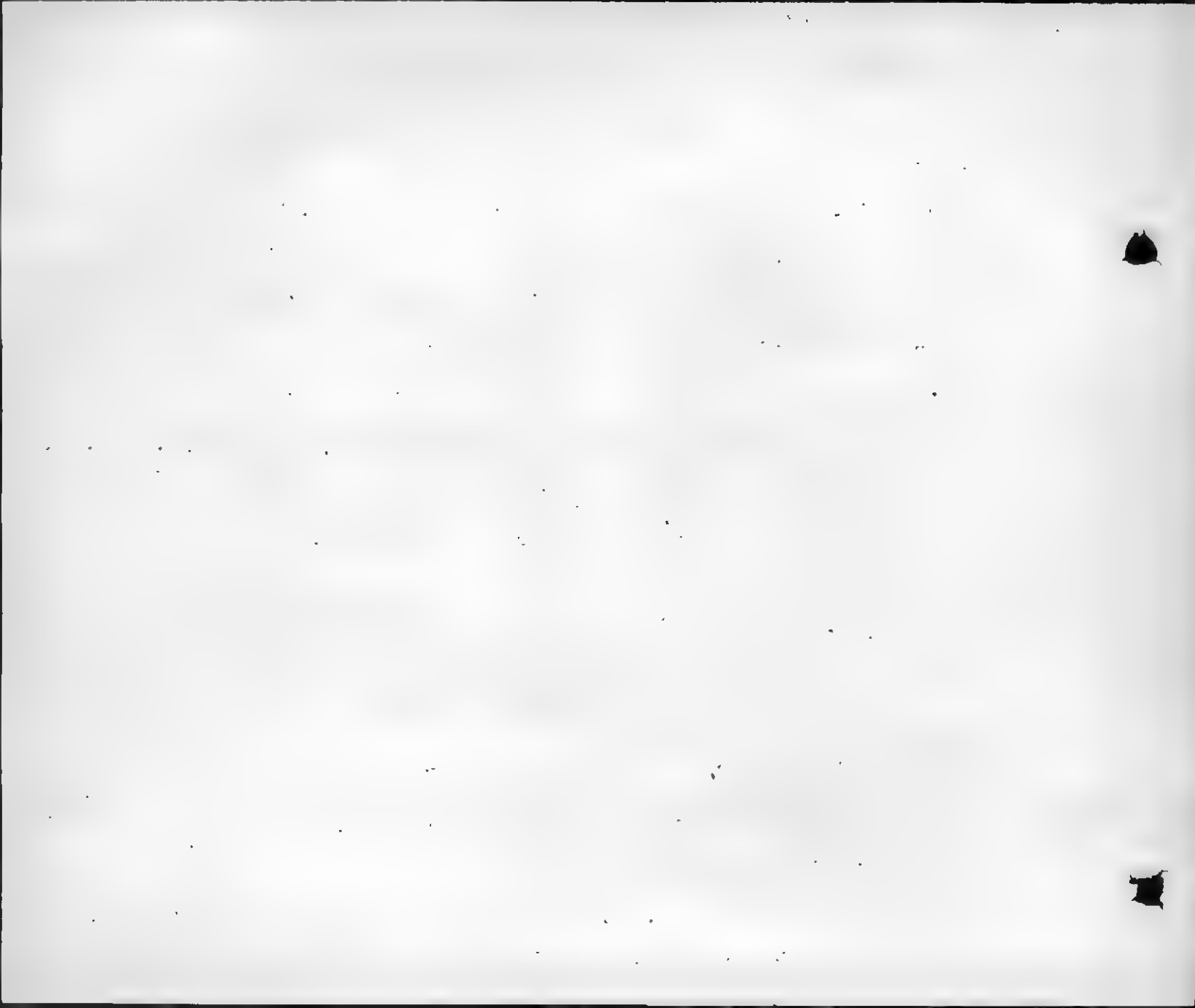
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11606

11620

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2016 Glenhaven Place				d. STREET ADDRESS 2016 Glenhaven Place			
3. NAME OF DECEASED (Type or print) First MORRIS Middle B Last LEVY				4. DATE OF DEATH Month October Day 20 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. 75 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer - Retired				10b. KIND OF BUSINESS OR INDUSTRY Poland		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Barnet Levy				14. MOTHER'S MAIDEN NAME Anna Esther Selensky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579-44-8580			
17. INFORMANT Sidney Levy				Address 2404 Lillian Dr., SS, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition DUE TO (b) Parkinson's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Decubitus ulcers PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/18/61 to 10/20/61 , that I last saw the deceased alive on 10/18/61 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Donald Nelson				ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spring, Md. DATE SIGNED 10/20/61			
PHYSICIAN'S NAME (Type) Dr. Donald Nelson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St, NW		24a. REC'D BY REGISTRAR DATE OCT 24 '61	
				24b. REGISTRAR'S SIGNATURE William S. Hanna			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

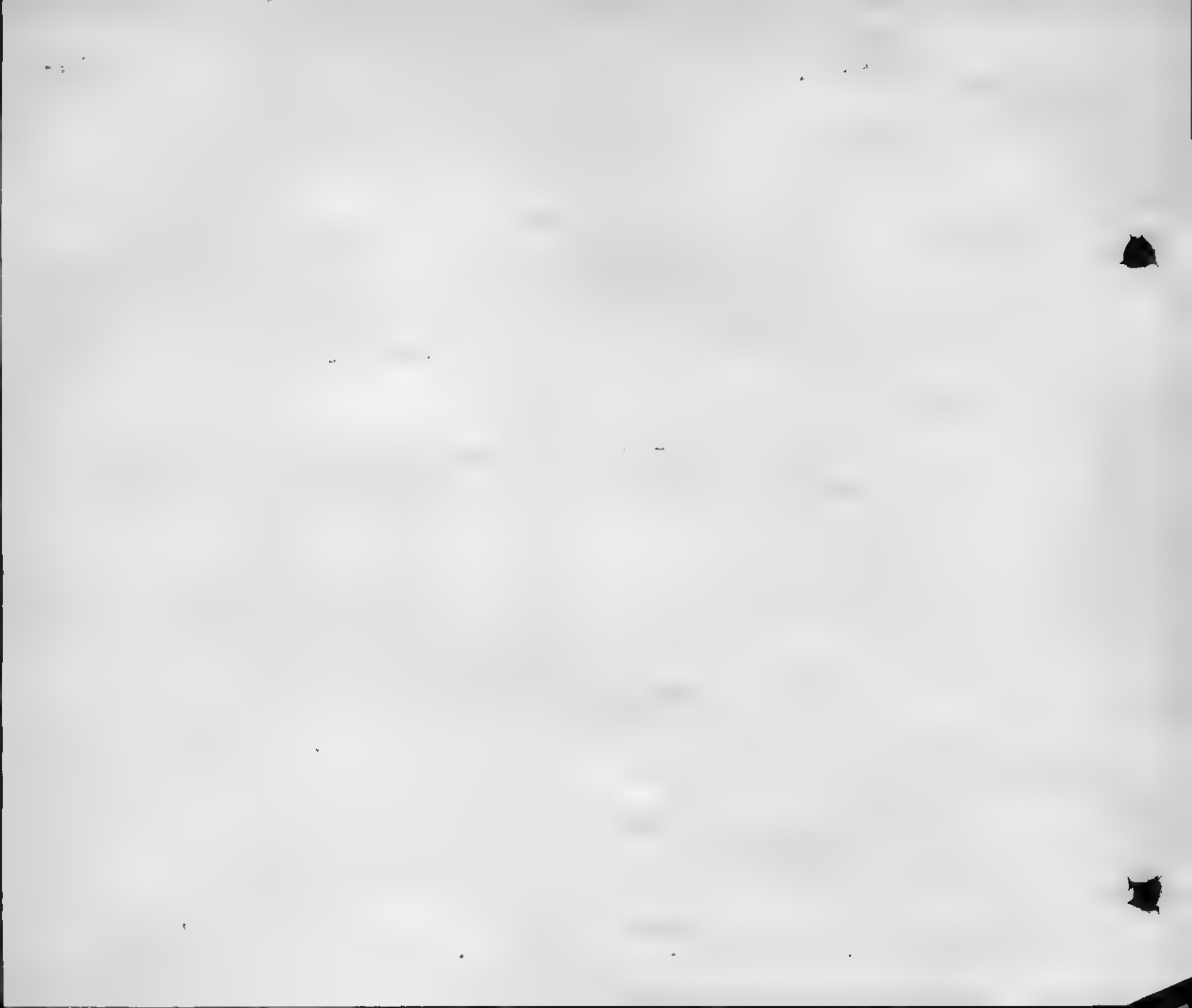
11621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11607

(M)

(I)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if inst. tution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8075 Georgia Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Lewis</u>			4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-1890</u>	9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR: Months <u>71</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plasterer</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W.I.</u>			16. SOCIAL SECURITY NO. <u>577-30-1397</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO <u>Coronary occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary occlusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>			17. INFORMANT <u>Montgomery County Police</u> Address <u>10-30-61</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>0</u> p.m. <u>0</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>11/2/61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Arlington County, Virginia</u>		
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>			24a. REC'D BY REGISTRAR <u>NOV 1 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			DATE <u>NOV 1 '61</u>		



CERTIFICATE OF DEATH

Reg. Dist. No. 11618

11622

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakema Park 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel Blanche Locke</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-76</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>85</u> Days <u>29</u> Hours <u>76</u> Min <u>4</u>	11. IF UNDER 24 HRS Months <u>85</u> Days <u>29</u> Hours <u>76</u> Min <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Massachusetts</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Not Known Collins</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not Known</u>	
17. INFORMANT <u>Hospital record</u>		Address <u>Hospital record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>Ereimic Syndrome</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of pancreas</u> DUE TO <u>with metastasis to liver</u> (c) <u>Embrown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis, Cholelithiasis & Sclerotic</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 19</u> , 19 <u>60</u> , to <u>Oct 29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>61</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u>		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u>Oct 29, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10/31/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>2901-14th St. N.W. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Oct 31 '61</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

1

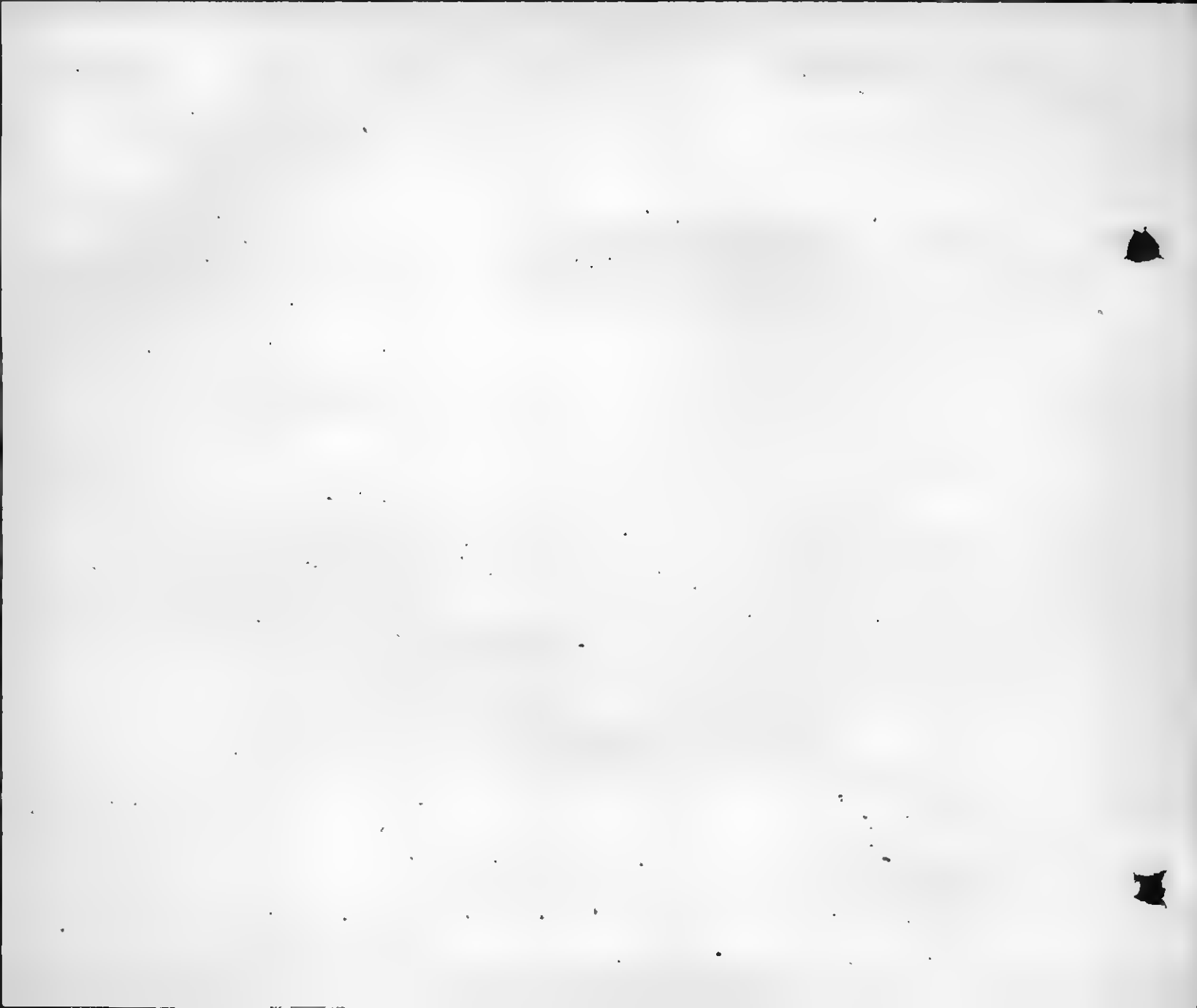
VS AIS (4)
15M 9/58

43-7

1

TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

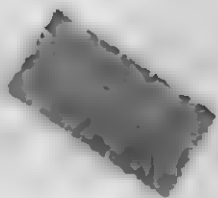
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11609

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6800 Laverrock Ct</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janet Olson Love</u> First Middle Last 4. SEX <u>Female</u> 5. COLOR OR RACE <u>White</u> 6. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>3-14-31</u> 8. AGE (In years last birthday) <u>30</u> yrs. 9. AGE (In years last birthday) <u>30</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Ill</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis M. Olson</u> 14. MOTHER'S MAIDEN NAME <u>Janet Inner</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Carl Love</u> Address <u>Stem 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Residual Rheumatic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death found to be 1 m b d.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-8-61</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u> 23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		22b. DATE THEREOF <u>10/10/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> ADDRESS <u>Bethesda, Maryland</u>		22d. LOCATION (City, town, or country) (State) <u>Chicago, Illinois</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

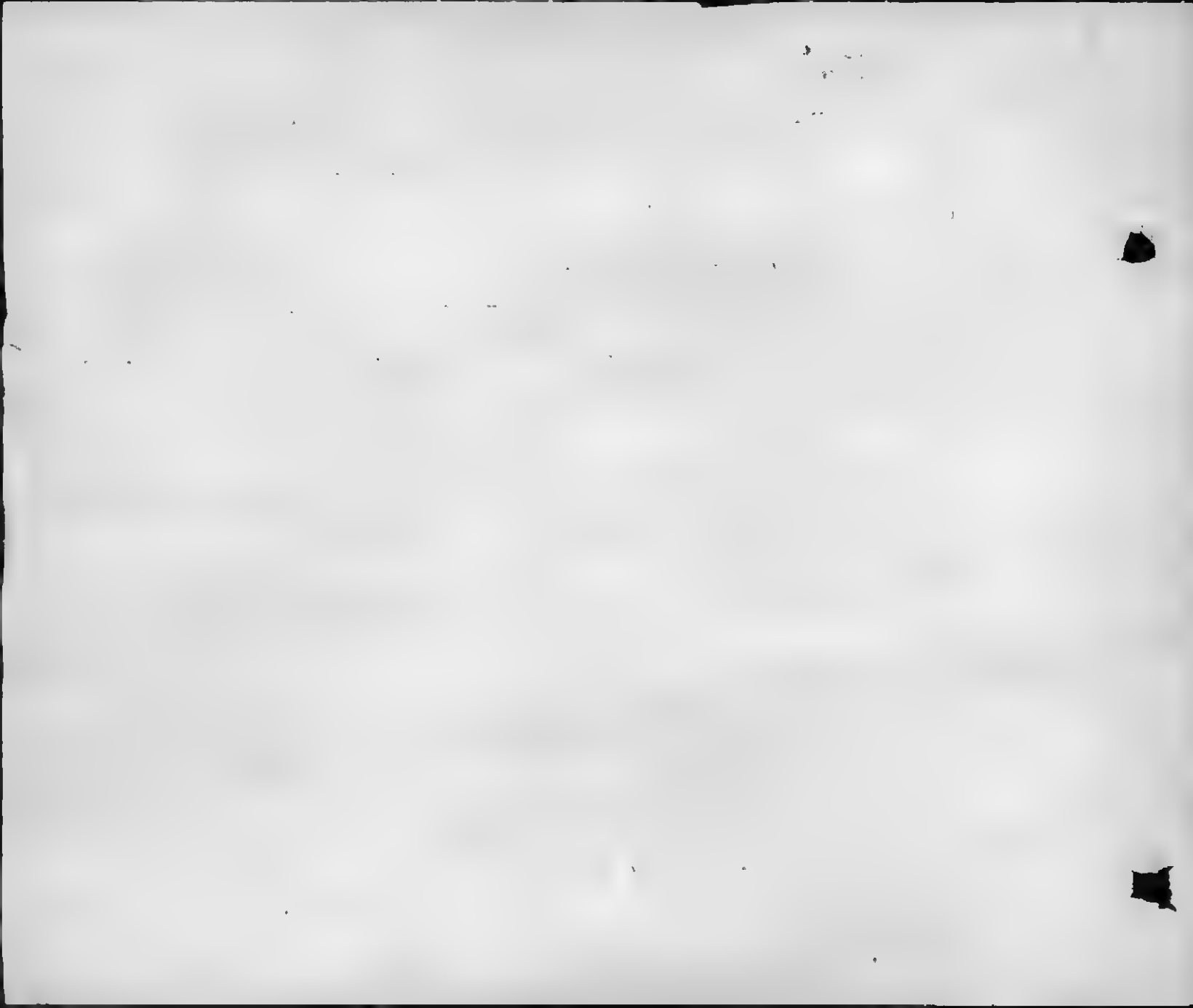
CERTIFICATE OF DEATH

11624

11610

1. PLACE OF DEATH a. COUNTY Montgomery County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY in 1b 7 1/2 hours		d. STREET ADDRESS Rt. 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lloyd, Harry Lee Loyd		4. DATE OF DEATH Month October Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-99
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR: Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern owner	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Loyd		14. MOTHER'S MAIDEN NAME Sarah Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (bilateral) DUE TO Hepatic coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Salmonella enteritidis (b) 48 hrs (c) many			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/6/61 to 10/6/61 , that (I) (we) last saw the deceased alive on 10/6/61 and that death occurred at 10/6/61 M. from the causes and on the date stated above.			
22a. SIGNATURE John P. Martin		22b. DATE SIGNED 10/6/61	
22c. PHYSICIAN'S NAME (Type) John P. Martin, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-61	
23c. NAME OF CEMETERY OR CREMATORY Boyd Cemetery		23d. LOCATION (City, town or county) (State) Boyd. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Hartner		25a. REC'D BY REGISTRAR 10/10/61	
25b. REGISTRAR'S SIGNATURE Charles E. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

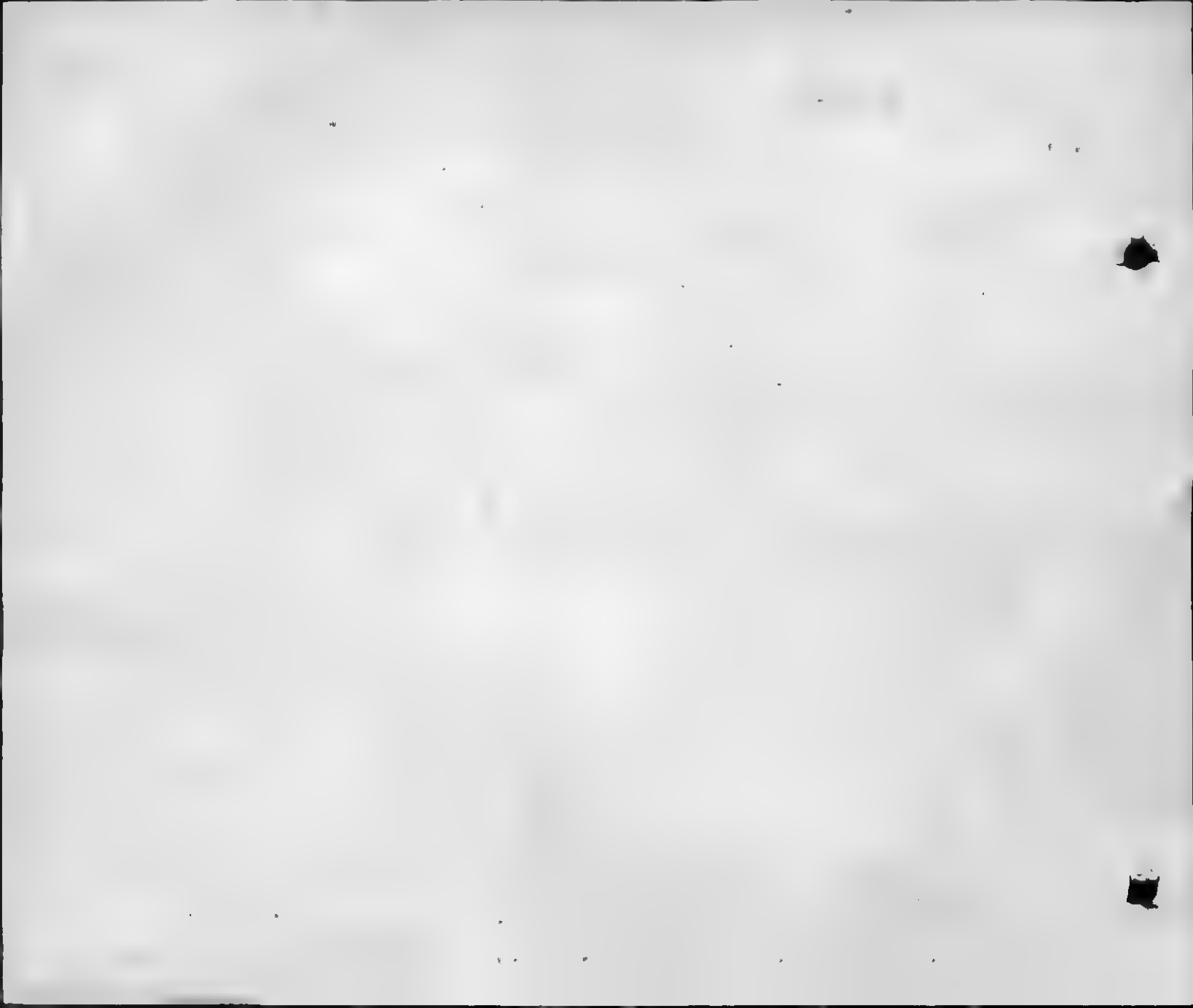
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11611

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 33 days 12 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1723 Jackson Street, Northeast	
3. NAME OF DECEASED (Type or print) Jesse Nesbit Lutton		4. DATE OF DEATH Month October Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1888 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Engraving	
11. BIRTHPLACE (County & State, or foreign country) Washington, District of Columbia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Lutton		14. MOTHER'S MAIDEN NAME Ella Grant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Patients' record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas 157 X DUE TO Conditions, if any, which gave rise to immediate cause (b) with generalized metastases (c) 4 months DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/15/61 to 10/12/61 , that (I) (we) last saw the deceased alive on 10/11/61 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED October 12, 1961	
22c. PHYSICIAN'S NAME (Type) Hugh Irey		22d. ADDRESS 7501 Riggs Rd. Lewis Lake Md.	
23a. BURIAL, CREMATION, or other disposition burial		23b. DATE THEREOF 10/16/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City, town or county) (State) Ft. Myer, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		25a. RECEIVED BY REGISTRAR DATE OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

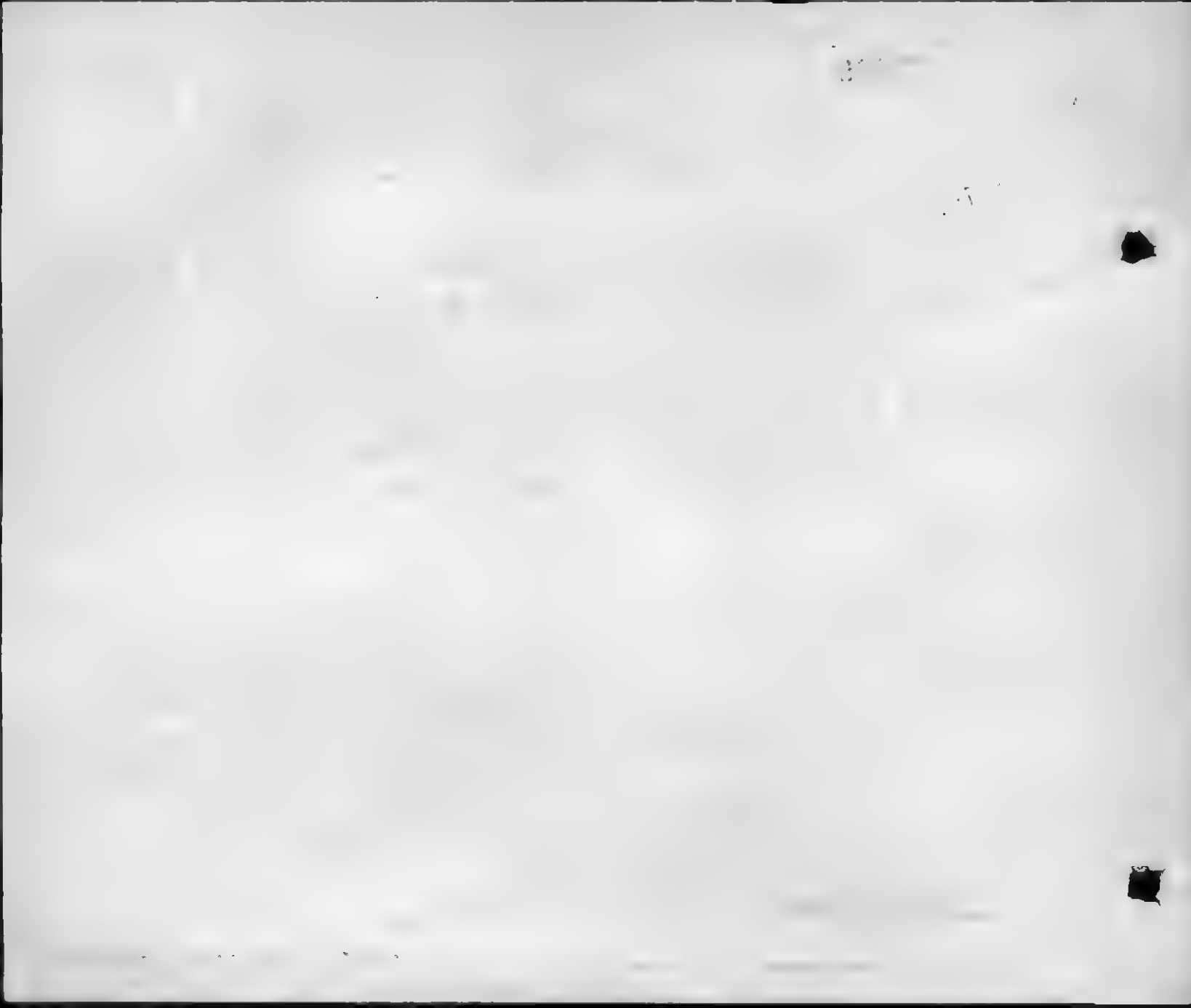
11626

11612

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JAKOMA PARK</u> c. LENGTH OF STAY in lb <u>2 mos 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brush San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>910 Sligo Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA MARIAM Marden</u>		4. DATE OF DEATH Month Day Year <u>10 8 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year <u>4-28-98</u> <u>63</u> yrs.
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Thomas V. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Reeves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hosp Record.</u>	
17. INFORMANT Address <u>Hosp Record.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Gall Bladder</u> DUE TO (b) <u>Enteric secondary metastases to Liver</u> DUE TO (c) <u>3 mos</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 mos</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>May 4 1935</u> Hour a.m. <u>10-8</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>May 4 1935</u>	
20f. (City or town) <u>Oct 8</u> (County) <u>1961</u> (State) <u>1961</u>		21. I certify that (I) (this hospital) attended the deceased from <u>May 4 1935</u> to <u>Oct 8 1961</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>61</u> , and that death occurred at <u>10:35</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Kenneth Langille</u> M.D.		22b. DATE SIGNED <u>10-8-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>924 Ellsworth Ave Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, D.C.</u> (State) <u>D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deed Funeral Home</u>		25a. REC'D BY REGISTRAR <u>10/9/61</u> 25b. REGISTRAR'S SIGNATURE <u>A 376 J. Scholze</u>	

OCT 13 '61

C. J. Knaus



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11627

Item 23b Film G300 11/10/61 mh

11613

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN IL 54 days. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Iowa b. COUNTY Hampton c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hampton d. STREET ADDRESS 203 4th Street	
3. NAME OF DECEASED (Type or print) Gary Lee Maricle		4. DATE OF DEATH October 31 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1943
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	9. AGE (In years last birthday) 18 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Hampton, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Maricle		14. MOTHER'S MAIDEN NAME Gladys Marie Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Aug 24 60 to present		16. SOCIAL SECURITY NO. present	
17. INFORMANT Mother: Mrs. Gladys M. Maricle, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Pulmonary Insufficiency (b) Mitostatic (c) rhabdomyosarcoma Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 6 month		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Sept. 8, 1961 to October 31 1961 , that (X) (we) last saw the deceased alive on October 31, 1961 , and that death occurred at 3:10 AM from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker		22b. DATE SIGNED October 31, 1961	
22c. PHYSICIAN'S NAME (Type) WILLIAM P. BAKER LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1, 1961	
23c. NAME OF CEMETERY OR CREMATORY Hampton Cemetery		23d. LOCATION (City, town or county) (State) Hampton, Iowa	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24. ADDRESS WASHINGTON, D.C.	
25a. REC'D BY REGISTRAR NOV 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11628

11614

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>16 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash SAN + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt RAINIER</u> d. STREET ADDRESS <u>3600 Rhode Island Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Joseph Mater</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-03</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>16</u> Min <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plate Maker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>	
13. FATHER'S NAME <u>Raffaele Matera</u>		14. MOTHER'S MAIDEN NAME <u>Stella Famiglietti</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2215 N. Capital</u>	
17. INFORMANT <u>Leonora Matera</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute myocardial infarction</u> DUE TO (c) <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>June</u> 19 <u>58</u> , to <u>Oct 26</u> 19 <u>61</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Oct 26</u> 19 <u>61</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James C Mandes</u>		22b. DATE SIGNED <u>10/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES C MANDES</u>		22d. ADDRESS <u>1401 16th St. N.W. WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>OCT 30, 1961</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>WASHINGTON, DC</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>N. Haulon</u>		25a. REC'D BY REGISTRAR <u>OCT 31 '61</u>	
ADDRESS <u>4748 Wisc. Ave NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



14615

Item 7 Film GC-17 10/17/61 inv

MEDICAL CERTIFICATION

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59



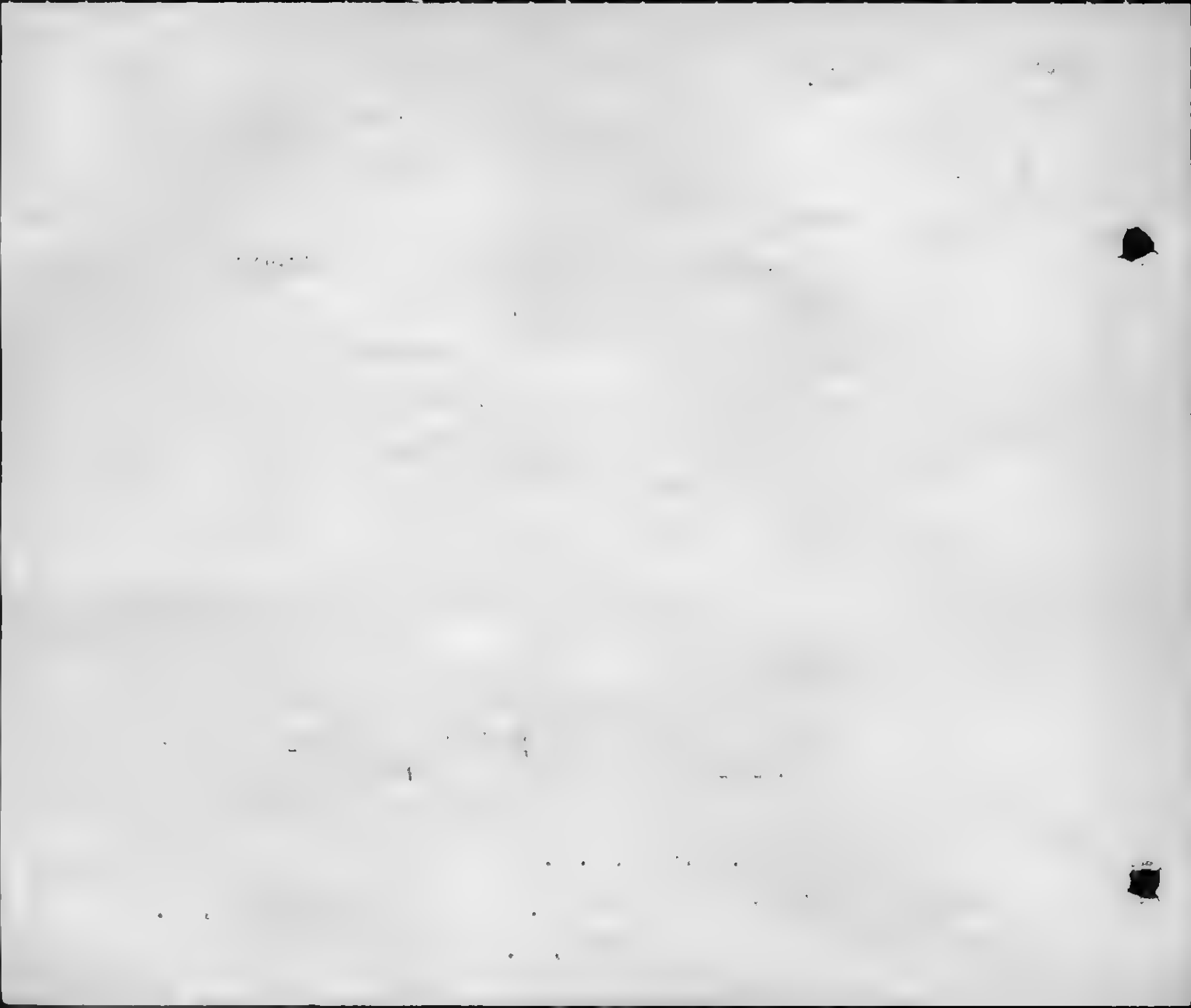
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

M

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL						2. USUAL RESIDENCE (Where deceased lived, If Institution; Res. since before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYTON d. STREET ADDRESS 13X-2					
3. NAME OF DECEASED (Type or print) ROLAND (NMN) MATTHEWS						4. DATE OF DEATH OCTOBER 10 19 61					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-1880		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARM WORKER				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND				11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
13. FATHER'S NAME NOT GIVEN						14. MOTHER'S MAIDEN NAME NOT GIVEN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN						16. SOCIAL SECURITY NO. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: + 4 X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO Nephrosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) Peritonitis due to strangulated left inguinal hernia											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JOHN Y											
20f. (City or town) JOHN Y (County) JOHN Y (State) JOHN Y											
21. I certify that (I) (was hospital) attended the deceased from JOHN Y to 10-10 , 1961, that (I) (was) last saw the deceased alive on 10-10-61 and that death occurred at JOHN Y M, from the causes and on the date stated above.											
22a. SIGNATURE CHARLES S. WHITAKER, M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10/11/61											
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D. 22d. ADDRESS Charlesville, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/14/61 23c. NAME OF CEMETERY OR CREMATORY Ash Memorial. 23d. LOCATION (City, town or county) Sandy Spring, Md. (State) Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md. 25a. REC'D BY REGISTRAR OCT 17 '61 25b. REGISTRAR'S SIGNATURE Wm S. Thomas											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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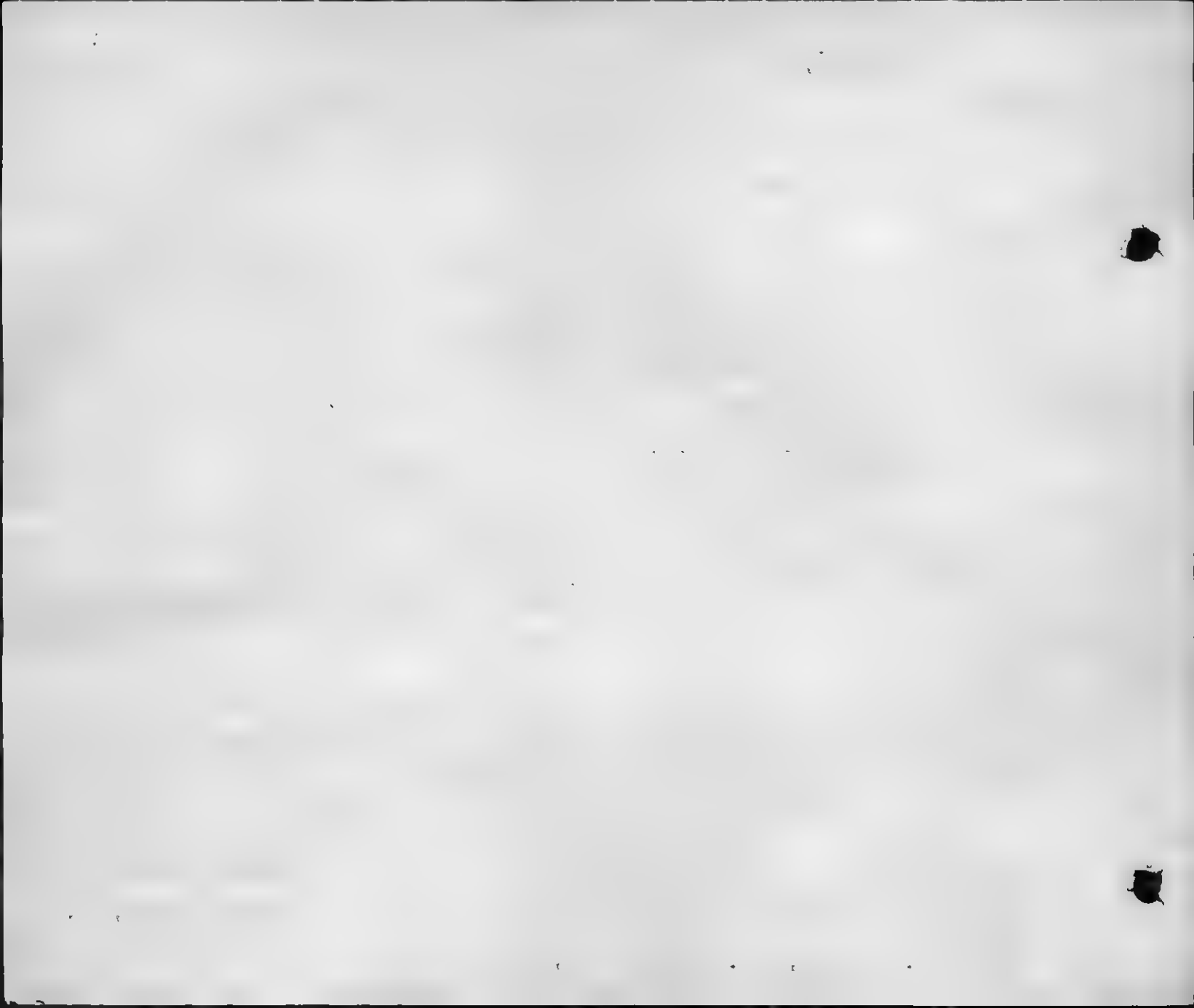
VR A15 (4)
15M 9/60

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.			
11631			
11617			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>6da 25min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			
3. NAME OF DECEASED (Type or print) <u>Leo Emanuel Mauchamek</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>David Mauchamek</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word and date of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Ica Keyser</u>	
16. SOCIAL SECURITY NO. <u>274-18-9009</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN stem compression</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Suspected intracerebral hemorrhage</u> (c) <u>Suspected intracranial aneurysm</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>6 days</u> <u>6 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> to <u>10/23</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>61</u> , and that death occurred at <u>10:55P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John T. Hord</u>		22b. DATE SIGNED <u>10/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John T. Hord MD</u>		22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George's County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>OCT 25 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11618

11632

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>49 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>8414 Lynwood Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Revina</u> <u>Meany</u> <u>Mayer</u> First Middle Last			4. DATE OF DEATH <u>October</u> <u>2,</u> <u>19</u> <u>61</u> Month Day Year		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>November 16, 1957</u> 9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Robert C. Mayer</u> 14. MOTHER'S MAIDEN NAME <u>Regina C. Meany</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Lymphocytic Leukemia</u> (c) <u> </u> (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>22 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 14, 1961</u> to <u>October 2, 1961</u> that (I) (we) last saw the deceased alive on <u>October 2, 1961</u> and that death occurred at <u>4:55 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>David Heywood</u> 22c. PHYSICIAN'S NAME <u>DAVID HEYWOOD, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		22b. DATE SIGNED <u>10/3/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> 23d. LOCATION (City, town or county) <u>Washington, D. C.</u> (State)		25a. REC'D BY REGISTRAR <u>OCT 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kimes</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

at the end of the

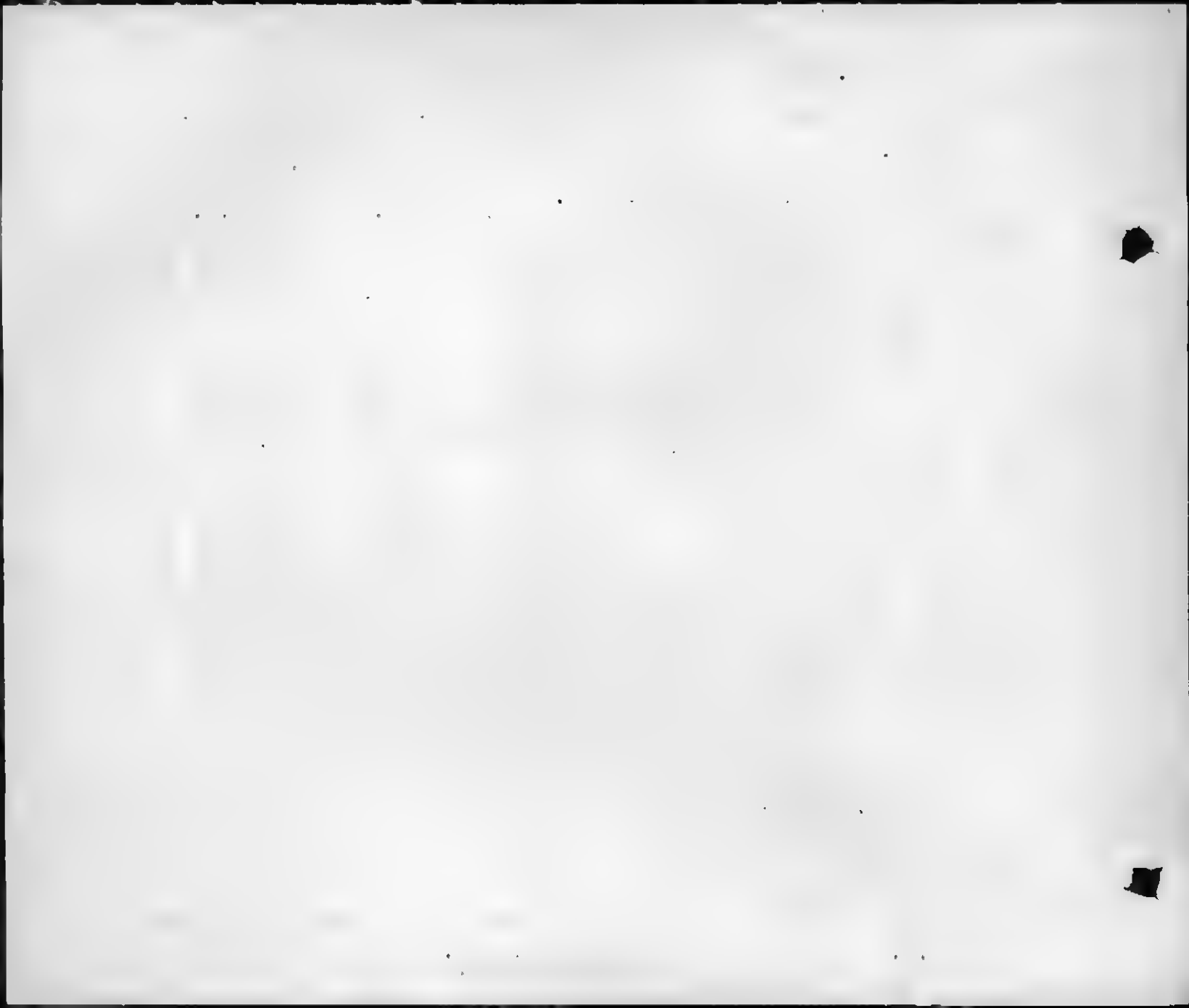
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11633

11619

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alta Vista Nursing Home		d. STREET ADDRESS 3945 Conn. Avenue, N.W.	
3. NAME OF DECEASED (Type or print) First CARRIE Middle LEE Last McCormick		4. DATE OF DEATH Month October Day 3 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1863
9. AGE (In years lost birthday) 98 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 3 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LEMUEL YERBY		14. MOTHER'S MAIDEN NAME JANE COUTTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Records at Nursing Home - Same #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO (b) 422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7:00 2 1961 , to Oct 3 1961 , that (I) (we) last saw the deceased alive on Oct 1 1961 , and that death occurred at 4:35 P M, from the causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DeWITT E. DeLawter, M.D.		22d. ADDRESS 8025 ABERDEEN RD. Bethesda, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/6/61	23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	23d. LOCATION (City, town, or county) (State) Richmond, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Company-2901 14th St., N.W.		25a. REC'D BY REGISTRAR DATE OCT 5 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hines			



1
FOR STATE
HEALTH DEPT.

(M)

(I)

VS. A15ME
5M 9/60

Items 20&21 Film 299
11-1-61

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11620

1. PLACE OF DEATH
a. COUNTY Montgomery **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Kensington
d. STREET ADDRESS 1 4013 Saul Road

3. NAME OF DECEASED (Type or print)
First Helen Maxine Middle McNenth Last McNenth
4. DATE OF DEATH Oct 24 1961
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 10-28-17 9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Arkansas 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Glover 14. MOTHER'S MAIDEN NAME Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year and date of service) 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT (James J McNenth) husband Address same as above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Synergistic poisoning
973.3 DUE TO Carbon monoxide, alcohol & barbiturates
Conditions, if any, which gave rise to immediate cause (b) —
(c) —
DUE TO —
(e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) —

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OF CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

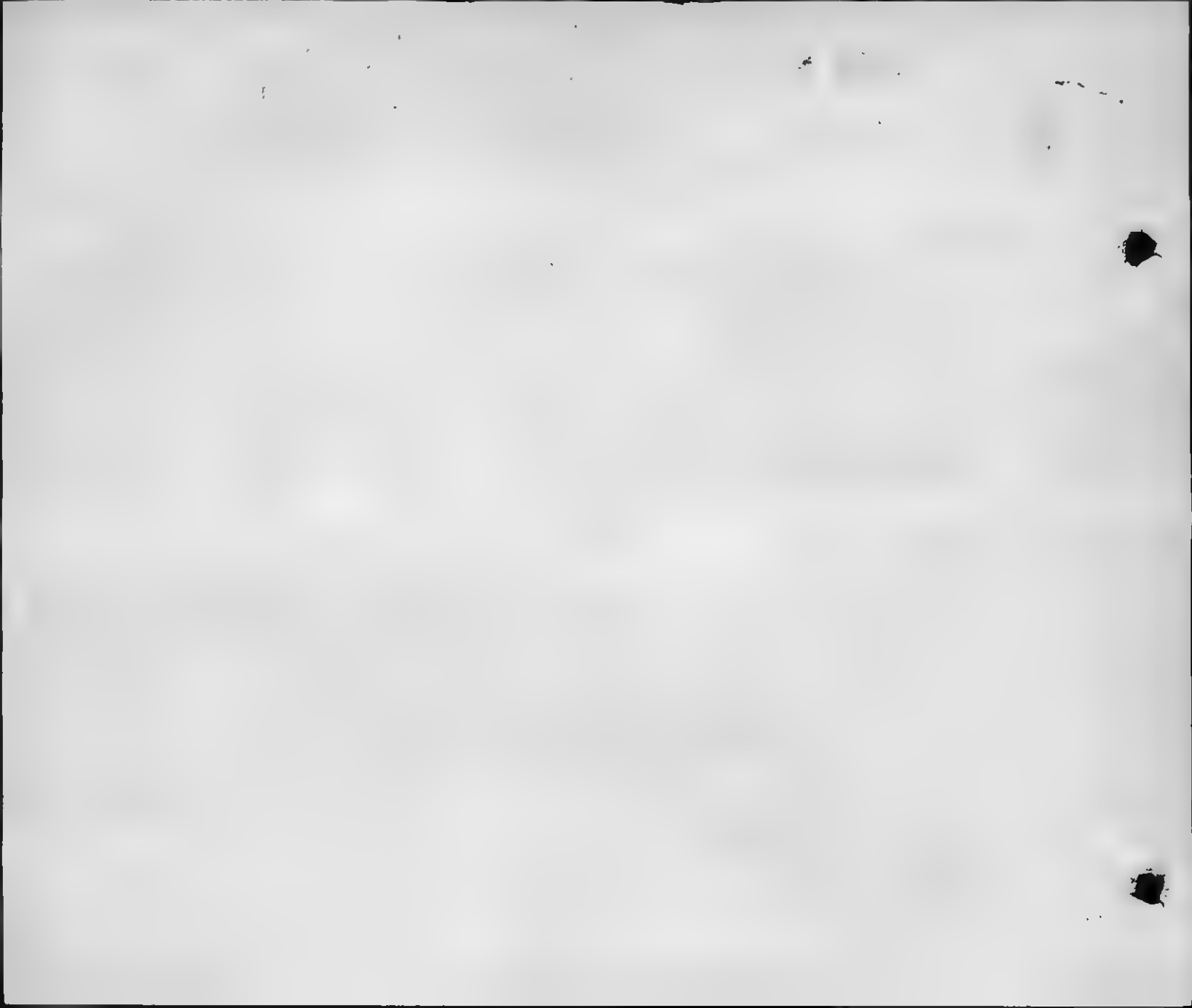
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 10-24-61

ACTUAL SIGNATURE Frank J. Broschaw M.D. EXAMINER'S NAME (Type) FRANK J. Broschaw Address (Street, c'ty, town, or county) Rockville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/27/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Rockville, Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland ADDRESS — 24a. REC'D BY REGISTRAR — 24b. REGISTRAR'S SIGNATURE — DATE OCT 26 '61

VS. A15ME
5M 9/60



CERTIFICATE OF DEATH

Reg. Dist. No. 11621

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Wisconsin</u> b. COUNTY <u>Milwaukee</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milwaukee</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Hosp. & Sanitarium</u>		d. STREET ADDRESS <u>86 x</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MEYER</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 13, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>5</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Mohr</u>	
14. MOTHER'S MAIDEN NAME <u>Albertina Mohr</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Record</u> <u>NONE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 22, 1957</u> to <u>Oct 18, 1961</u> , that I last saw the deceased alive on <u>Oct 18, 1961</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D. <u>345 University Blvd., W. Silver Spring, Md.</u>		DATE SIGNED <u>OCT 18/61</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, M.D., 345 University Boulevard West, Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>—</u>	22d. LOCATION (City, town, or county) (State) <u>MILWAUKEE, WISC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyman Bo.</u> ADDRESS <u>Wash. D.C. 1300-N St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

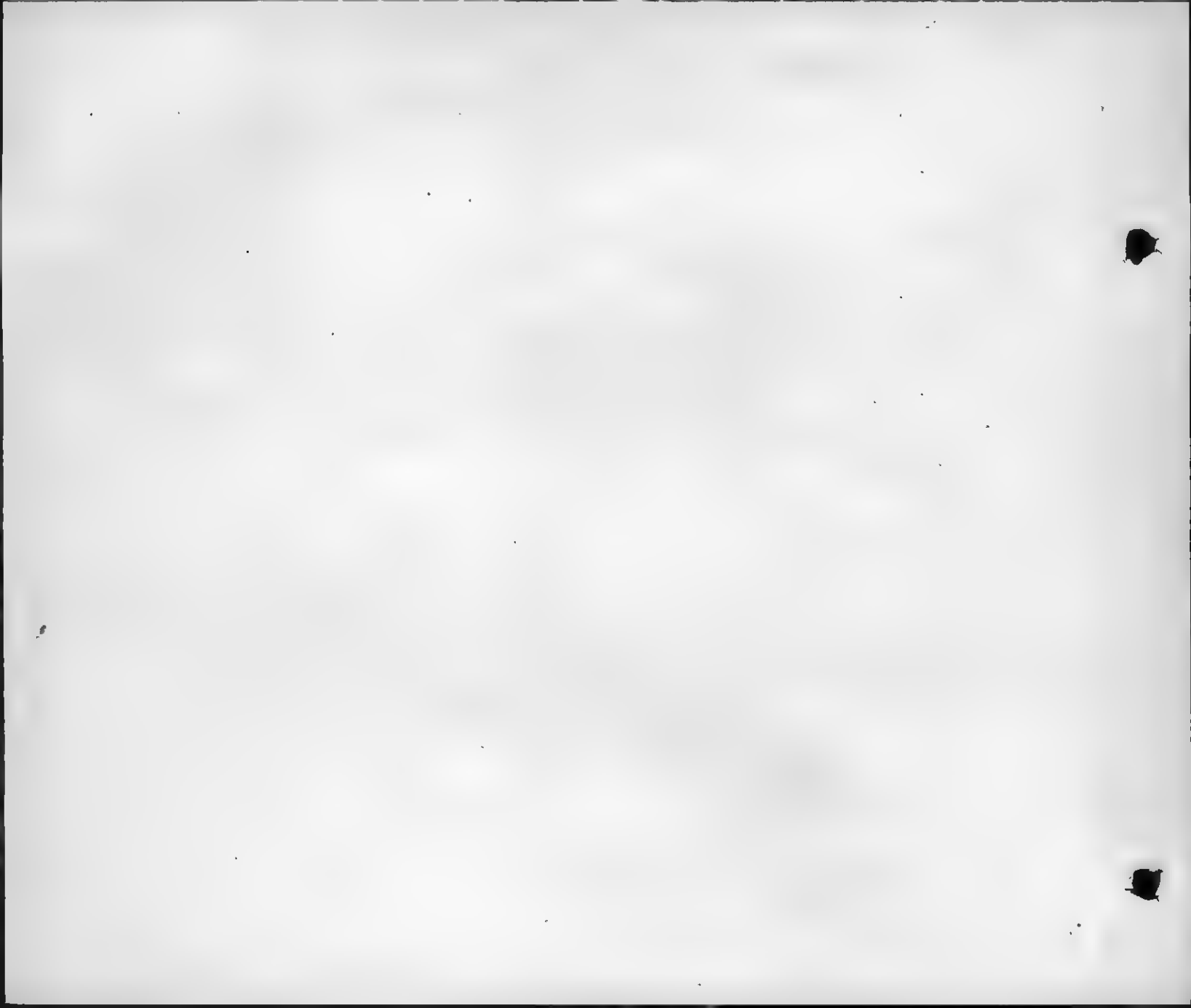
11623

11637

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Dist. D.C.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaboard</u>				d. STREET ADDRESS <u>4714 - Chesapeake St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Arthur Paul Moore</u>				4. DATE OF DEATH <u>Oct. 19 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto repair</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Clara Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Army soldier</u>				16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1</u>		17. INFIRMITY Address <u>52nd St. N.Y.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary atherosclerosis</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>September 19, 1961</u> to <u>Oct 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 19, 1961</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Michael M. Hefley</u> M.D.				22b. DATE SIGNED <u>11/17/61</u>		22c. PHYSICIAN'S NAME (Type) <u>MICHAEL M. HEFLEY</u>	
22d. ADDRESS <u>U.S. ARMY MEDICAL CENTER WASH. D.C.</u>							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside M. E. Cemetery</u>	
						23d. LOCATION (City, town, or county) (State) <u>Dover, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Oct 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



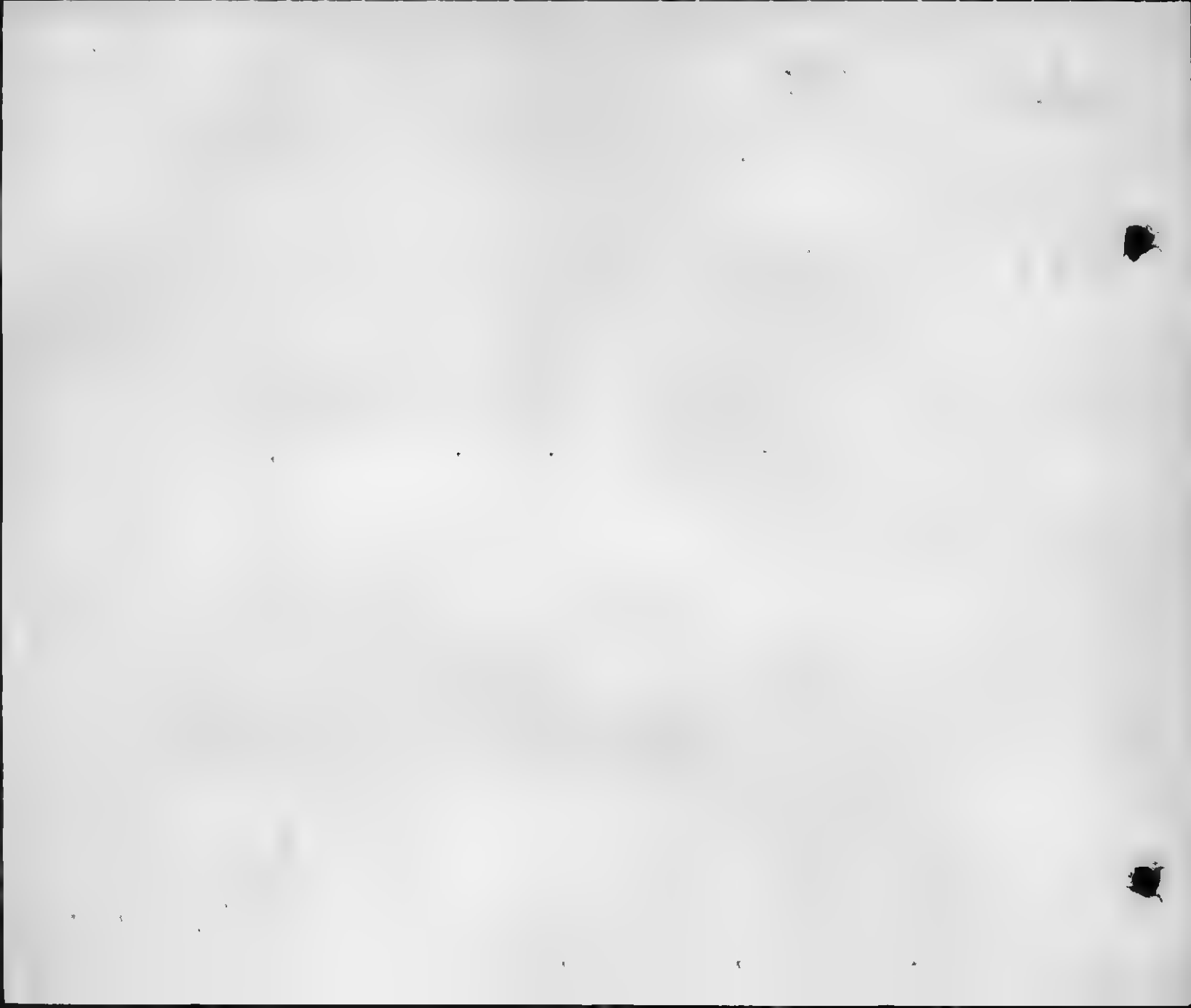
TO HITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San & Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Hamilton St. N.W. d. STREET ADDRESS 18 Hamilton St. N.W.	
3. NAME OF DECEASED (Type or print) Dorothy Hetzel Miller		4. DATE OF DEATH Oct. 16 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-79
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gabriel Eisenhart		14. MOTHER'S MAIDEN NAME Mary Ann Swinford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Fred J. Miller		18. ADDRESS 8717 - 23rd Avenue, Adelphi, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism Conditions, if any, which gave rise to immediate cause (b) Congestive heart failure (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 days - 2 years - unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-4 1959 to 10-16 1961 , that (I) (we) last saw the deceased alive on 10-16 1961 , and that death occurred at 4:02 A.M. from the causes and on the date stated above.			
22a. SIGNATURE EINO MAGI		22b. DATE SIGNED 10-16-61	
22c. PHYSICIAN'S NAME (Type) EINO MAGI		22d. ADDRESS 918 University Blvd. E. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince George's County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25. REC'D BY REGISTRAR 1-8-61	
25a. ADDRESS 434 Georgia Avenue, Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna	



1 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

18&21 Film 298
10-26-61
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11638

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Annapolis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 79 West Street
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)
First Douglas Middle Dean Last Moore

4. DATE OF DEATH
Month October Day 5 Year 1961

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June 28, 1909

9. AGE (In years, if UNDER 1 YEAR, last birthday) 52 yrs. Months 2 Days 1 Hours 19 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces

10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force

11. BIRTHPLACE (State or foreign country) Alabama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes

16. SOCIAL SECURITY NO. Hospital records

17. INFORMANT Hospital records Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pending Broncho-pneumonia, hemorrhagic, bilateral
DUE TO
Conditions, if any, which gave rise to immediate cause (b) 491X
(a), stating the underlying cause last. (c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED October 5, 1961

ACTUAL SIGNATURE Frank J. Broschart

EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10 Oct 1961

22c. NAME OF CEMETERY OR CREMATORY Arlington National

22d. LOCATION (City, town, or country) (State) Arlington Va.

23. FUNERAL DIRECTOR THE J. H. LINES 2901 14th St N.W. Wash. ADDRESS

24a. REC'D BY REGISTRAR DATE OCT 10 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and fill in any event, within 72 hours after death, be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

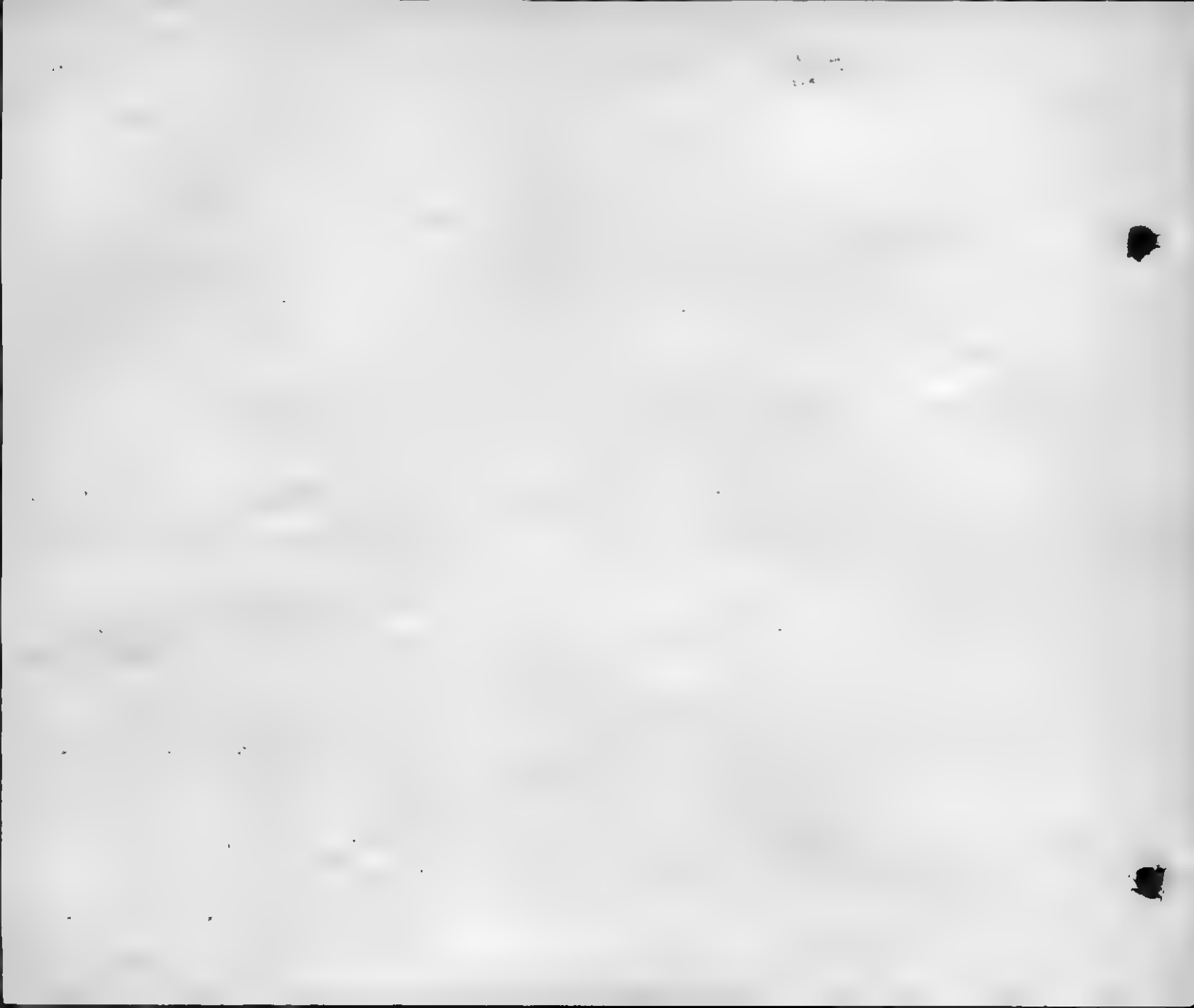
VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11639

1625

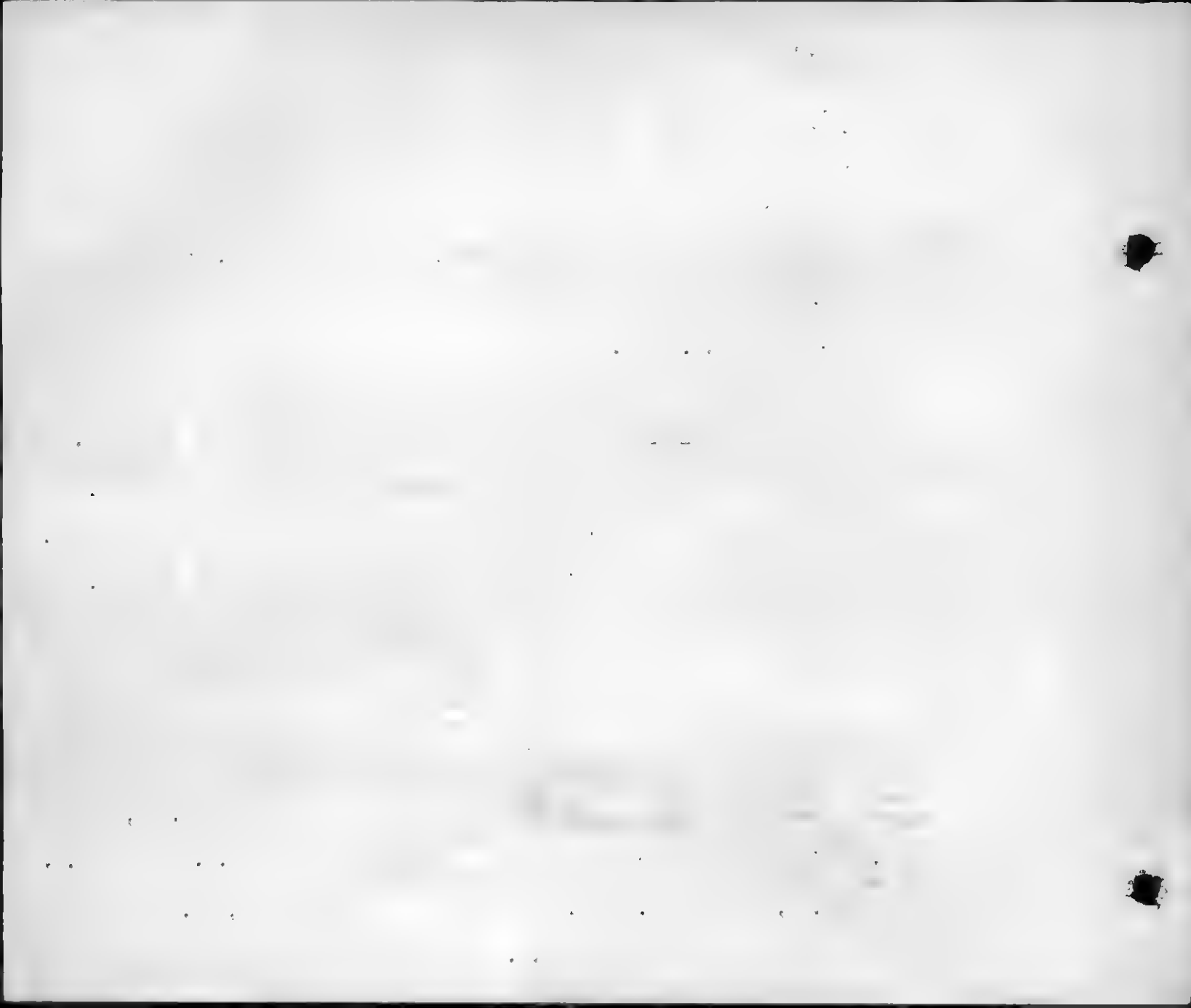
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1516 Oakview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lena Ann Morris</u>		4. DATE OF DEATH <u>10 - 5 - 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>71</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer Bradway</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO (b) <u>arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>limited chest</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Jan 3</u> 1961 to <u>Oct 5</u> 1961, that (I) (<u>no</u>) last saw the deceased alive on <u>Oct 5</u> 1961, and that death occurred at <u>11:55 A</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Merrill M. Cross</u> M.D.		22b. DATE SIGNED <u>10/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS MD</u>		22d. ADDRESS <u>8248 Georges ave, Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/5/1961</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Wash D C</u>		23d. LOCATION (City, town or county) (State) <u>Springfield, Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



11626

MEDICAL CERTIFICATION

VR A1S (4)
1SM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11641

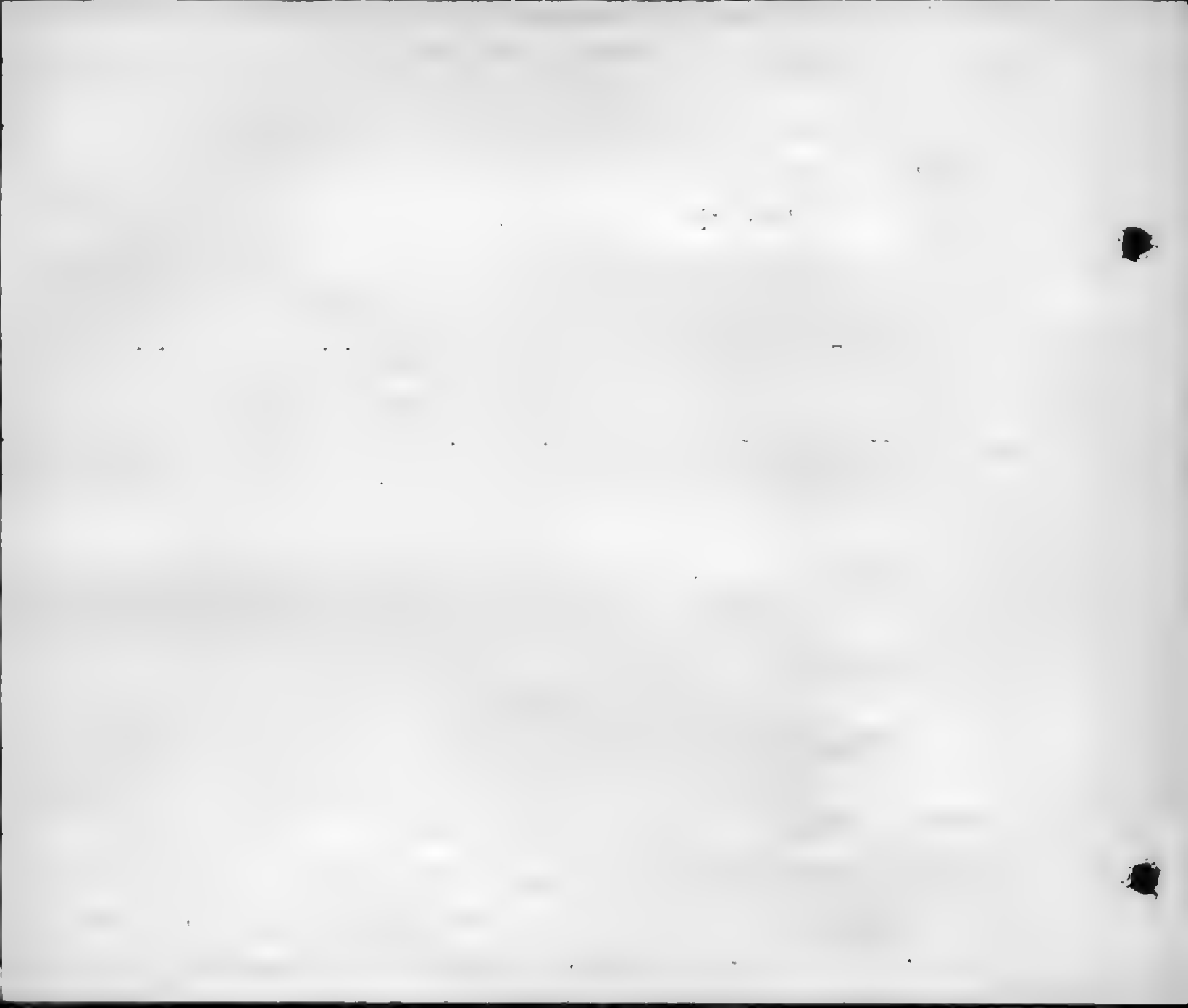
CERTIFICATE OF DEATH

Reg. Dist. No. 11627

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>seven years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3409 Floral Street,</u>				d. STREET ADDRESS <u>3409 Floral Street</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Lighter</u> Middle <u>Nail</u> Last				4. DATE OF DEATH <u>October 8</u> 19 <u>61</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 NOV 1882</u>		9. AGE (In years last birthday) <u>78 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counter Clerk-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. John F. Nail</u> Address <u>3409 Floral Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Artery Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>57 yrs</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>61</u>				20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1958</u> , to <u>8 Oct</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8 Oct</u> , 19 <u>61</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton L. White</u>				ADDRESS (Street, city or town, state) <u>1134 Georgia Ave Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>11/34</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



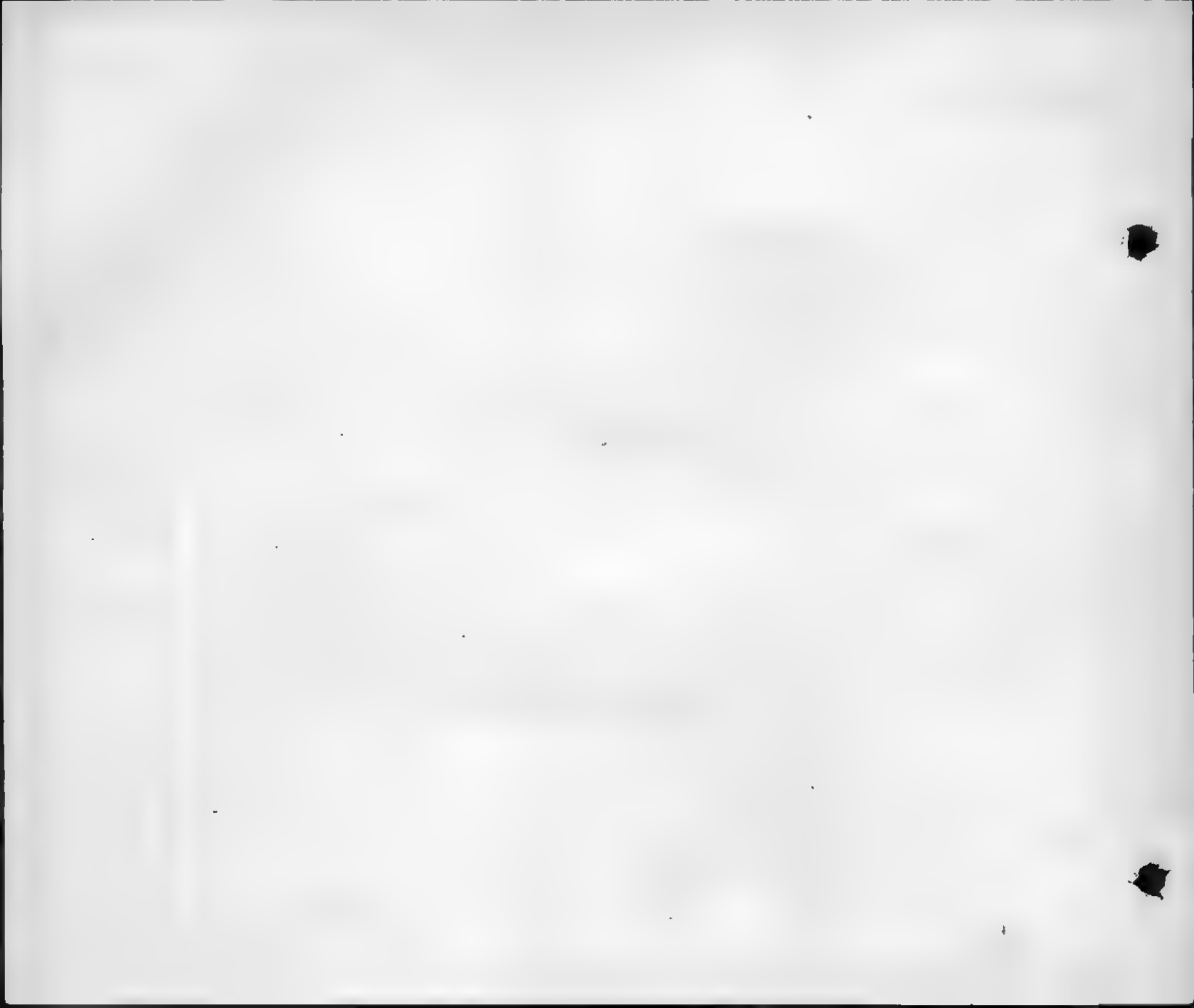
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11642 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11628

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
3. NAME OF DECEASED (Type or print) First <u>SAM</u> Middle <u>NEIDORF</u> Last <u>NEIDORF</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years lost birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ZEUS NEIDORF</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>WASH SAN & HOSP RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MASSIVE MYOCARDIAL INFARCTION, SMALL AND LARGE BLOOD VESSELS</u> DUE TO <u>ATHEROSCLEROSIS OF THE AORTA</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ATHEROSCLEROSIS OF THE AORTA</u> DUE TO (c) <u>ATHEROSCLEROSIS OF THE AORTA</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHOLELITHIASIS AND GALLBLADDER</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>OCT 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT 16, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B. P. LAFSKY</u>		22b. DATE SIGNED <u>OCT 16, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. P. LAFSKY</u>		22d. ADDRESS <u>2025-EYE ST. NW WASH. D.C.</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ADAS ISRAELI CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Widney J. ...</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 16 '61</u>	
ADDRESS <u>4217 9th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

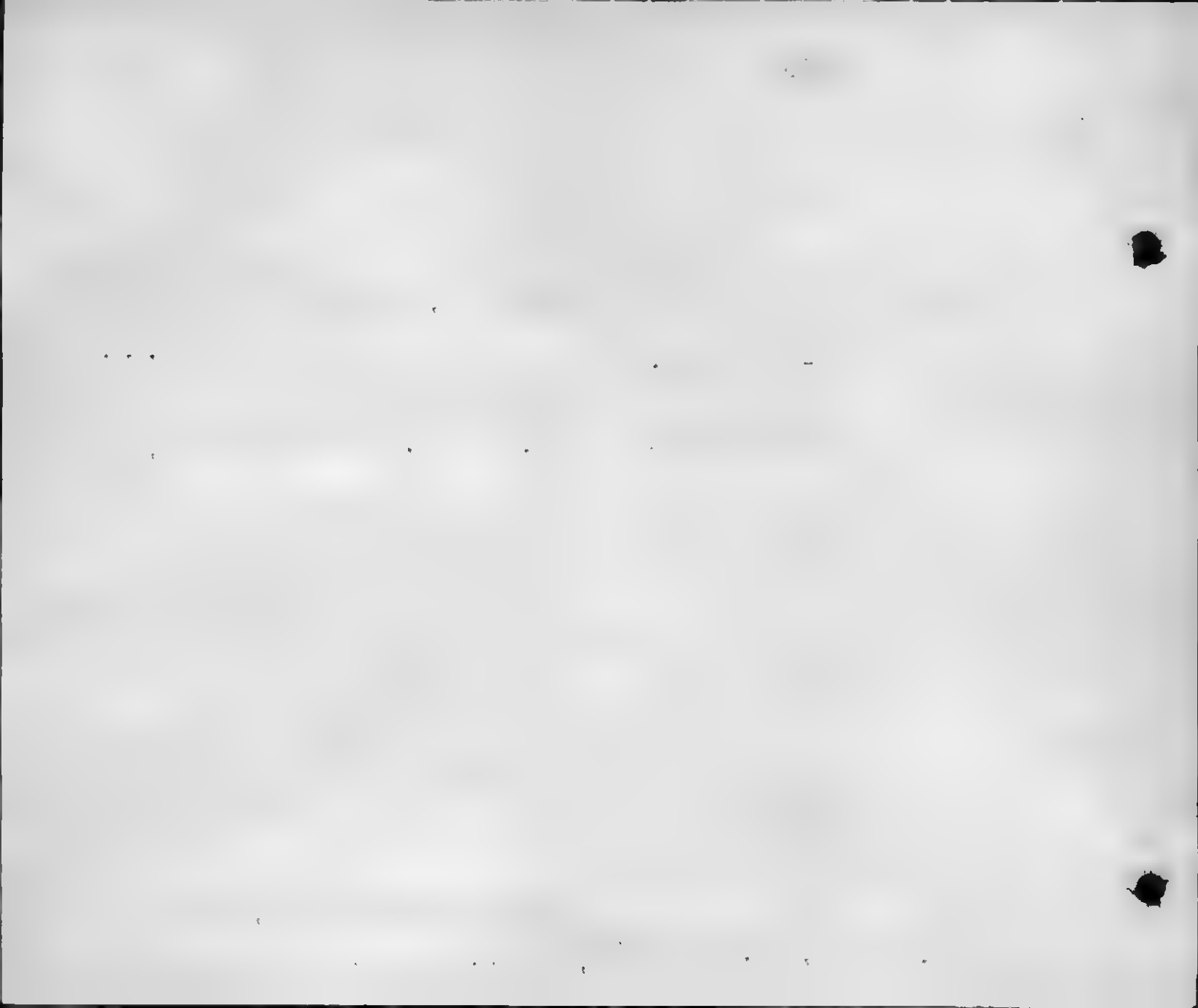
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11643

CERTIFICATE OF DEATH

11623

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8512 CEDAR STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD Marshall</u> 5. SEX <u>MALE</u> 6. CO. OR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>October 25, 1874</u> 9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>30</u> Days <u>19</u> Hours <u>61</u>		4. DATE OF DEATH <u>OCTOBER 30</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Production Manager-Retired Govt. Printing</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Nevils</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWI</u> 16. SOCIAL SECURITY NO. <u>578-22-6085</u> 17. INFORMANT <u>Mrs. Evelyn D. Nevils</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Laws</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ATHEROSCLEROSIS</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e): <u>MILD HYPERTENSION</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a.m.</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29</u> , 19 <u>61</u> , to <u>OCT. 30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>OCT. 29</u> , 19 <u>61</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>James A. Roberts</u> 22b. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> 22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MARYLAND</u> 22e. DATE SIGNED <u>10/30/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/1/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> 25. REC'D BY REGISTRAR <u>OCT 31 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

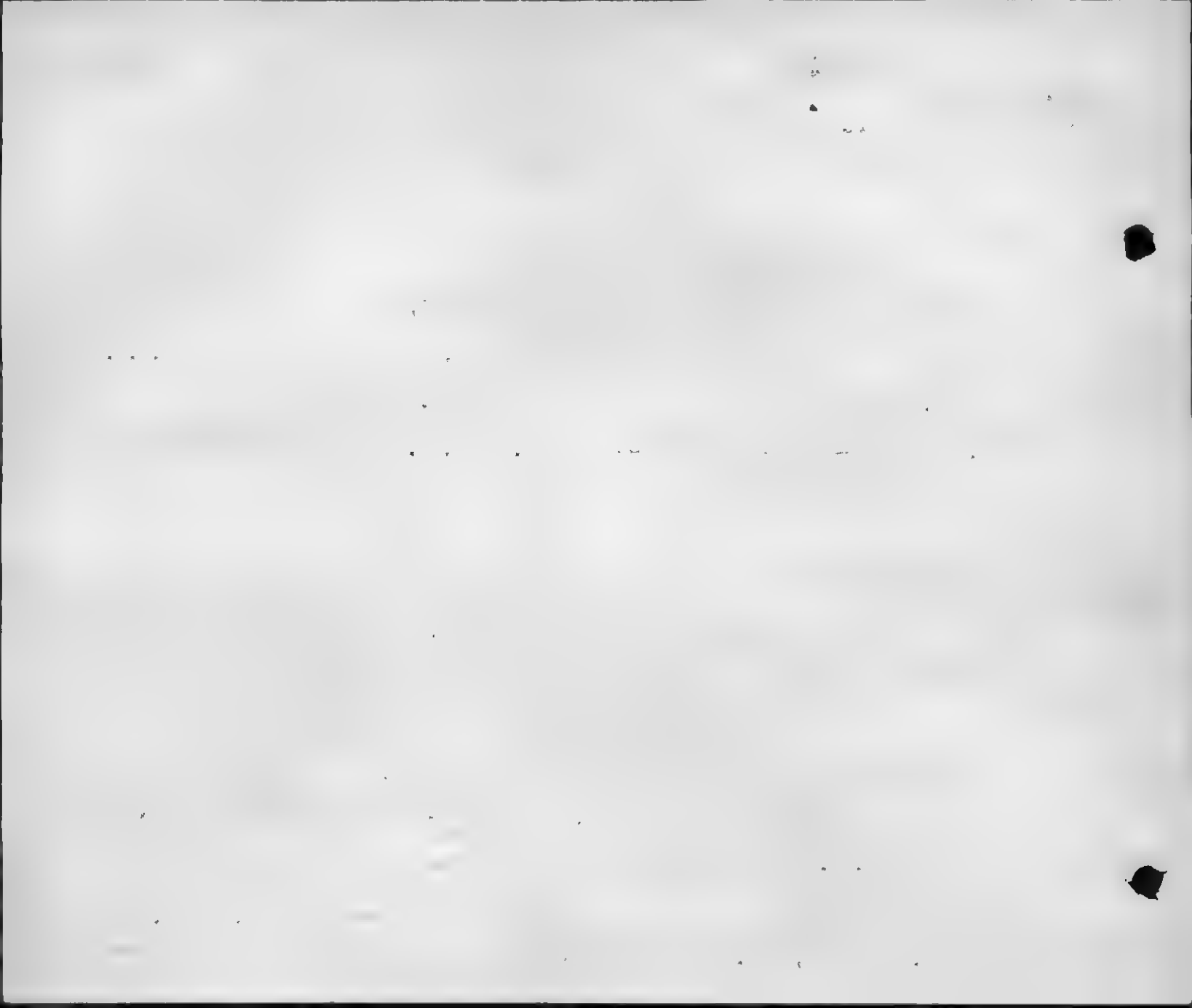


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11644 CERTIFICATE OF DEATH 11650									
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 7 years		2. USUAL RESIDENCE (Where deceased lived, if different from: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9101 Providence Street				e. STREET ADDRESS 9201 Providence Street					
3. NAME OF DECEASED (Type or print) Margaret Morris Norman		First		Middle		Last		4. DATE OF DEATH October 30 1961	
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		8. DATE OF BIRTH November 11, 1872		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher retired		10b. KIND OF BUSINESS OR INDUSTRY Delaware Schools		11. BIRTHPLACE (County & State or foreign country) Lewes, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Norman				14. MOTHER'S MAIDEN NAME Annie W. Norman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 163-10-3179					
17. INFORMANT Col. Chas. J. Norman				Address 9101 Providence Street, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Carcinoma of right breast</i> (c) <i>Arteriosclerotic Heart Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> 1959 to <i>Oct 30</i> 1961, that (I) (we) last saw the deceased alive on <i>Oct 30</i> 1961, and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>J. Marion Bankhead</i>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Oct 30, 1961</i>	
22c. PHYSICIAN'S NAME (Type) Dr. J. Marion Bankhead				22d. ADDRESS 9241 Columbia Boulevard,					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Church		23d. LOCATION (City, town or county) (State) Sussex County, Lewes, Delaware			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Byrna H. Ziska</i> Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Maryland		25. REC'D BY REGISTRAR NOV 1 61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11651

FOR STATE
HEALTH DEPT:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK

c. LENGTH OF STAY in 1b

41 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASHINGTON SAN & HOSP.

3. NAME OF DECEASED (Type or print)

FLORENCE

R. NORRIS

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

☐ NEVER MARRIED

☒ WIDOWED

☐ DIVORCED

8. DATE OF BIRTH

7-30-77

9. AGE (In years last birthday)

84 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF WHAT COUNTRY

Amer.

13. FATHER'S NAME

William H. Ritter

14. MOTHER'S MAIDEN NAME

Marie

XXXXXXXXXXXX Dippel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

Yes Unknown

17. INFORMANT

Wash. San & Hosp.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

PULMONARY EMBOLISM, BILATERAL

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUETO

BRONCHOPNEUMONIA BILATERAL

DUE TO

RUINS 2ND & 3RD DEGREE, THORAX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

3 DAYS

"

6 WEEKS

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Fell down fire while burying trash at home

20c. TIME OF INJURY

Month, Day, Year

12:16 p.m. 8-31 1961

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Kensington

(County)

Montgomery Md

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

EXAMINER'S NAME (Type)

FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

10-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/13/61

22c. NAME OF CEMETERY OR CREMATORY

Oak Hill Cemetery

22d. LOCATION (City, town, or county)

Washington, D. C.

(State)

23. FUNERAL DIRECTOR

ADDRESS

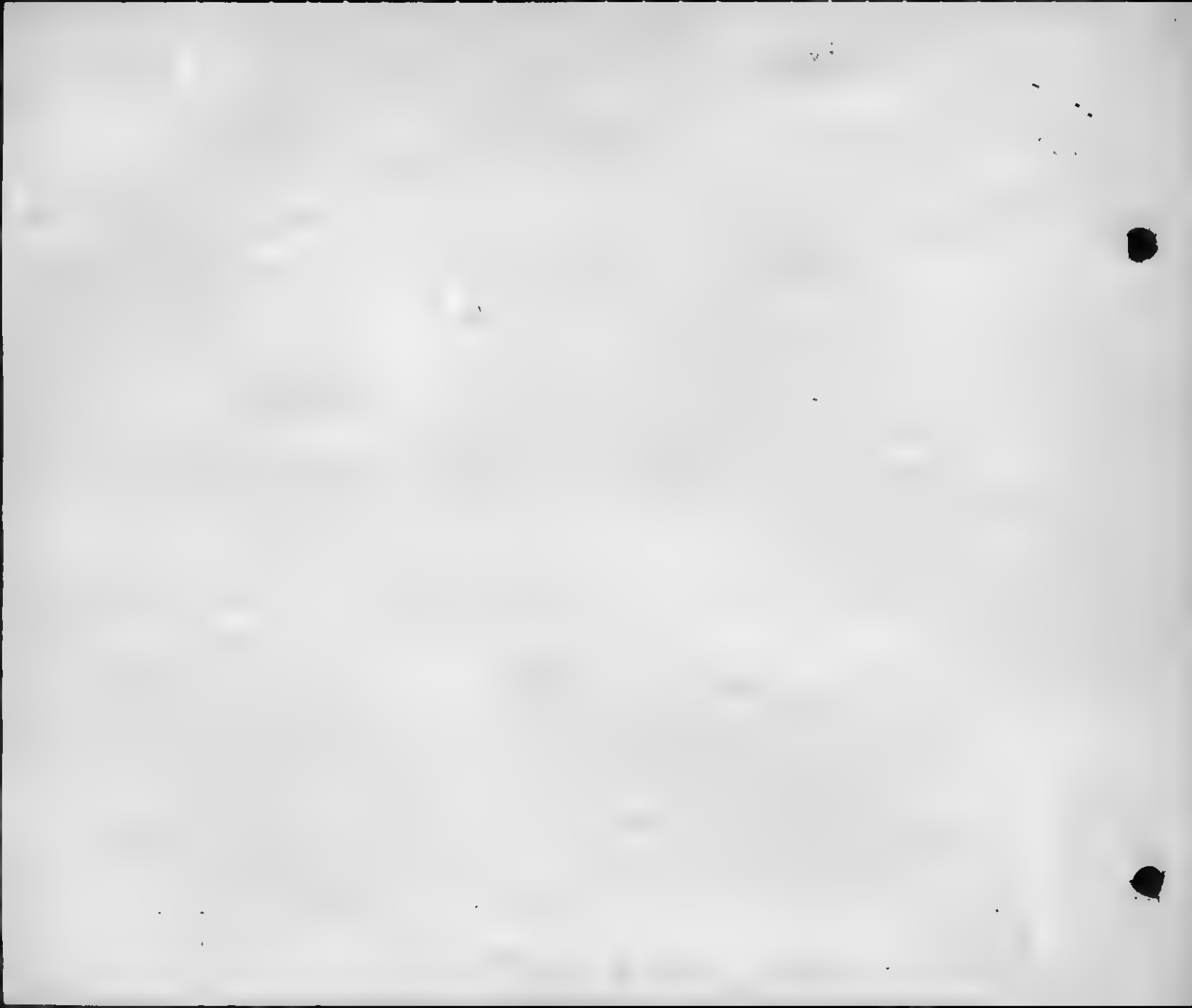
Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR

DATE OCT 13 '61

24b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11646

11632

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN TB <u>79 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Vennings</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bert Adams Road</u> d. STREET ADDRESS <u>Bert Adams Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Purcell</u> First Middle Last <u>North</u>		4. DATE OF DEATH Month Day Year <u>October 12 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 12, 1932</u> 28 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u>		9b. AGE (In years last birthday) <u>28</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Willie North</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Beasley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>Feb 1952 to Pres 260 60 5524</u> 17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma in liver (primary unknown)</u> DUE TO (b) <u>156.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Urinary tract infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Urinary tract infection</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>> 5 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 25</u> <u>1961</u> to <u>Oct 12</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 12</u> <u>1961</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John W. Brackett, Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOHN W. BRACKETT, JR., LT MC USA</u>		22b. DATE SIGNED <u>12 Oct 1961</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Shipment</u>		23b. DATE THEREOF <u>14 Oct 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Unknown at present</u>		23d. LOCATION (City, town or county) (State) <u>Georgia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. F. TAYLOR</u>		25a. REC'D BY REGISTRAR <u>OCT 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS <u>909 6th St. N.W. Washington, D. C.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11647

CERTIFICATE OF DEATH

Item 21 Film 3297-10/13/61 iwk

11633

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN

7 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Pennsylvania

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Wilkes-Barre

d. STREET ADDRESS

33 West South Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

ANNA

Middle

MARION

Last

OBICI

4. DATE OF DEATH

October

Day

Year

9, 1961

5. SEX

Female

White

6. CO. OR RACE

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

August 23, 1909

9. AGE (in years last birthday)

52 yrs.

IF UNDER 1 year

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Obici

14. MOTHER'S MAIDEN NAME

Susie Yannocone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WW II

None

17. INFORMANT

The Medical Record, The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Myelogenous leukemia with involvement of spleen, kidneys, nodes, and large bowel

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DOE TO

Acute hemorrhage, large bowel

DOE TO

Bronchopneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from October 2, 1961 to October 9, 1961, that (I) (we) last saw the deceased alive on October 9, 1961, and that death occurred at 6:35 AM from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

J. David Heywood M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

10-9-61

22b. DATE SIGNED

22d. ADDRESS

The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE THEREOF

10-9-1961

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

WILKES-BARRE, PA.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Joseph Gawler & Son, Inc. 1756-Pa. Ave. NW, Wash. DC

25a. REC'D BY REGISTRAR

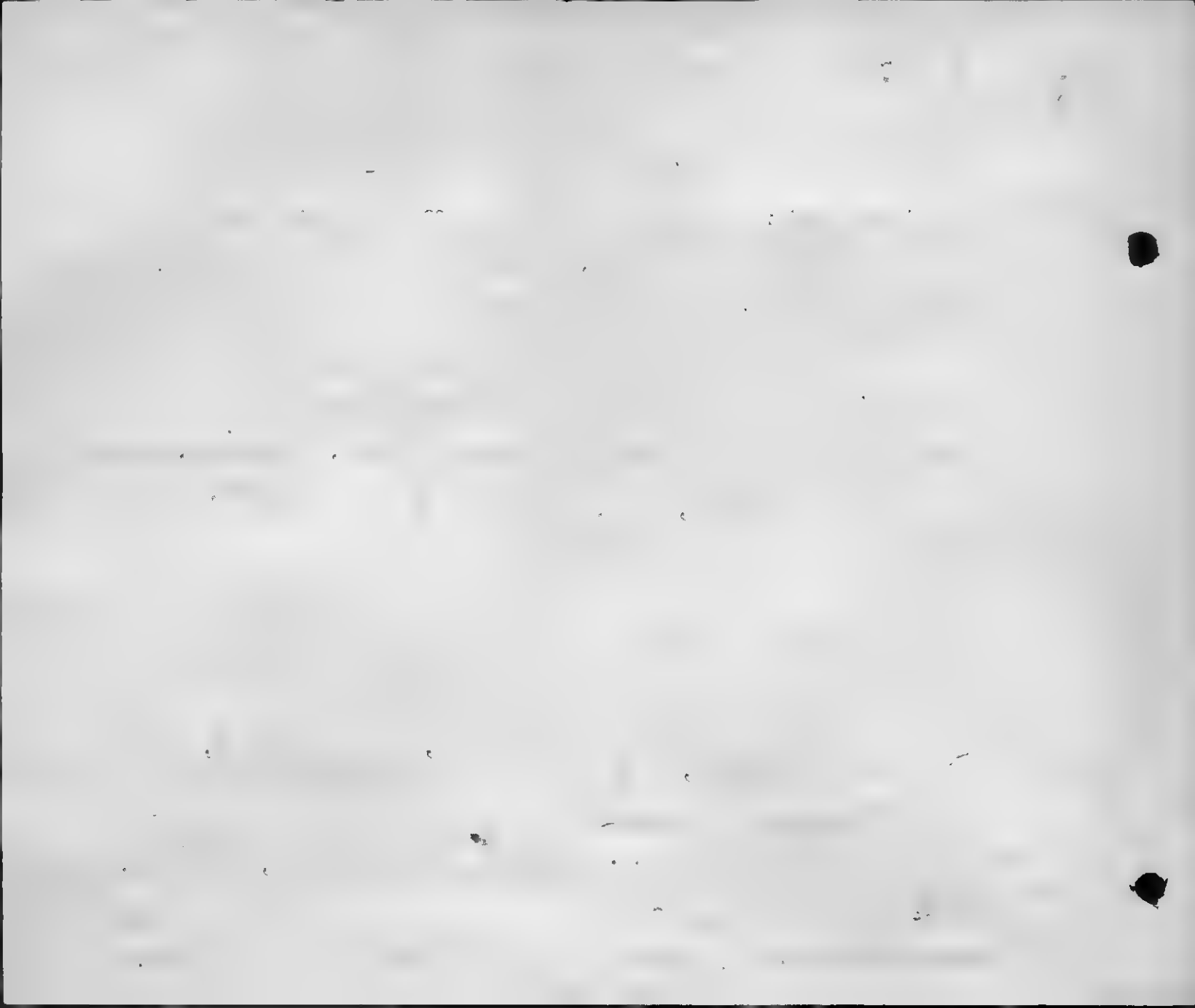
25b. REGISTRAR'S SIGNATURE

DATE OCT 11 '61

Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
M 9/60



1
FOR STATE
HEALTH DEPT.

TO PREPARE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

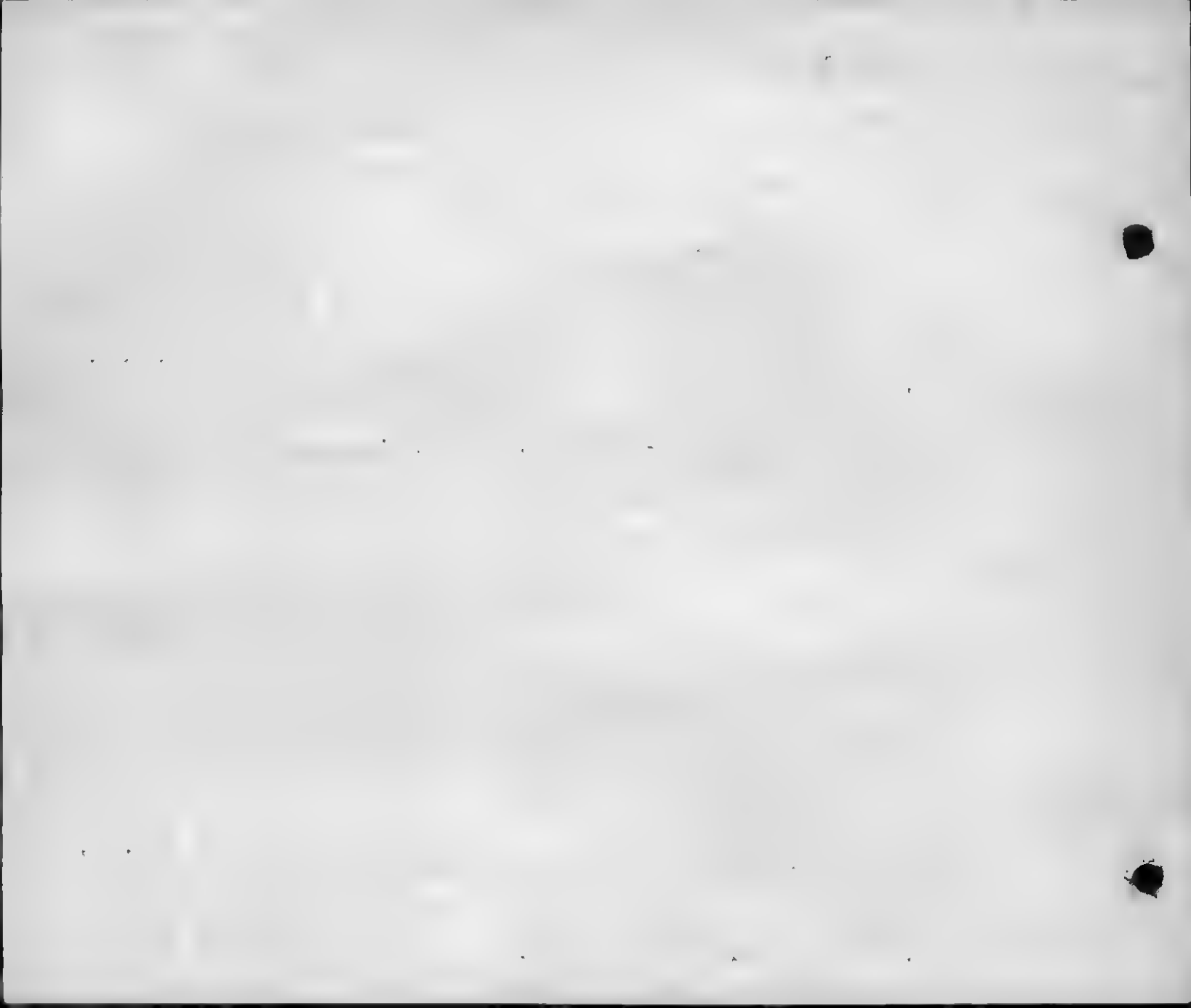
VS. A15ME
SM 7/59

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11654											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 3305 PENDLETON DRIVE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3305 PENDLETON DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD ANDREW O'NEILL				4. DATE OF DEATH Month OCTOBER Day 29 Year 1961							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 9, 1909		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 29 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (MERKLE PRESS)				10b. KIND OF BUSINESS OR INDUSTRY PRINTING				11. BIRTHPLACE (State or foreign country) MASSACHUSETTS			
13. FATHER'S NAME ANDREW O'NEILL				14. MOTHER'S MAIDEN NAME JOSEPHINE FAHEY				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. ce) YES WW #2				16. SOCIAL SECURITY NO. 044-07-8178				17. INFORMANT MRS. EDITH L. O'NEILL, 3305 PENDLETON DRIVE, Address SILVER SPRING, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO MYOCARDITIS Conditions, if any, which gave rise to immediate cause (b) 122.2 (c) 122.2 (e), stating the underlying cause last, 122.2 DUE TO 122.2											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 122.2											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 122.2							
20c. TIME OF INJURY Month 10 Day 29 Year 1961 Hour 12 a.m. 22 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 122.2			
20f. (City or town) 122.2				20g. (County) 122.2				20h. (State) 122.2			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart				M.D. FRANK J. BROSCHART				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/31/61				22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY			
22d. LOCATION (City, town, or country) ARLINGTON, VIRGINIA				22e. (State) 122.2				22f. (County) 122.2			
23. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.				24a. REC'D BY REGISTRAR OCT 31 '61			
24b. REGISTRAR'S SIGNATURE Arthur L. Hines				DATE OCT 31 '61				24c. REGISTRAR'S SIGNATURE Arthur L. Hines			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

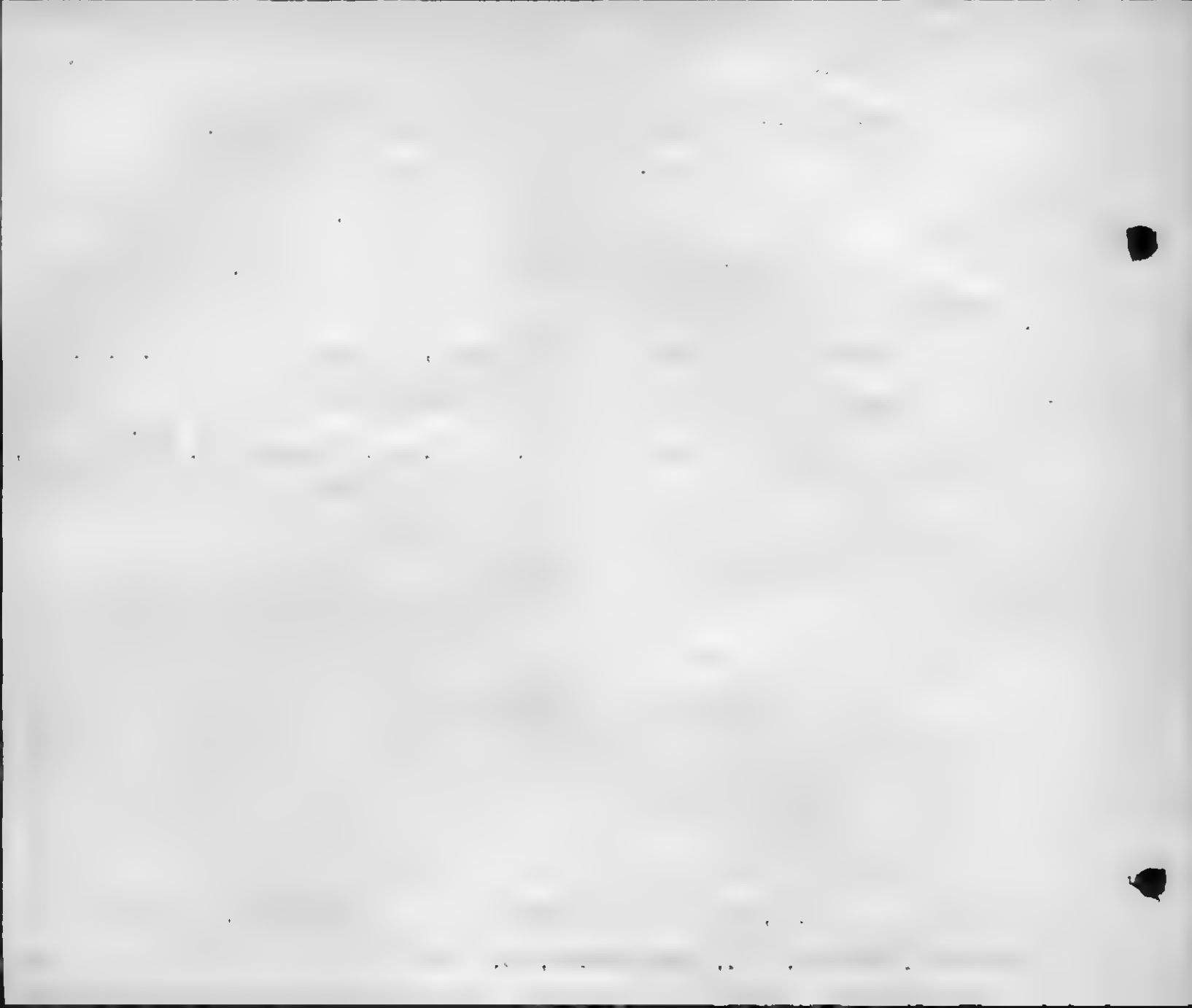
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11649

CERTIFICATE OF DEATH

11635

1. PLACE OF DEATH a. COUNTY MONTGOMERY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton, Md c. LENGTH OF STAY IN 1b Oct. 19, 1961 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland d. STREET ADDRESS 735 Sligo Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Caroline M. Osmann		4. DATE OF DEATH Month Oct. Day 28 Year 19 61	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1880	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker (retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (Country & State, or foreign country) Walnut, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nicholas Ohlsen		14. MOTHER'S MAIDEN NAME Karen Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. John P. Dee, 735 Sligo Ave., Silver Spring, Md.		Address (Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular insufficiency 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension, DUE TO (c) diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 12, 1961 , to October 28, 1961 , that (I) (we) last saw the deceased alive on Oct. 28 19 61 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Veronika Troost M.D.		22b. DATE SIGNED 10-28-1961	
22c. PHYSICIAN'S NAME (Type) VERONIKA TROOST		22d. ADDRESS 10236 N. H. Ave. Silver Spring Md	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BURIAL NOV. 2, 1961		23c. NAME OF CEMETERY OR CREMATORY HILLS OF REST CEMETERY	
23d. LOCATION (City, town or county) (State) SIOUX FALLS, SOUTH DAKOTA		24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Ziska WARNER E. PUMPHREY, INC., SILVER SPRING, MD.	
25a. REC'D BY REGISTRAR OCT 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11650
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11636

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN TB <u>46 days</u>		d. STREET ADDRESS <u>1405 28th. St., NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Avery</u> Last <u>Packer</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 6, 1897</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>561 38 0026</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Newport, R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Stephen Packer</u>		14. MOTHER'S MAIDEN NAME <u>Harriette Jordan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI, WWII, Korea</u>		16. SOCIAL SECURITY NO. <u>WIFE: Mrs. Bernice D. Packer, same as #2</u>	
17. INFORMANT <u>WIFE: Mrs. Bernice D. Packer, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF THE KIDNEY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (this hospital) attended the deceased from <u>September 12 1961</u> to <u>October 27, 19 61</u> that (I) (we) last saw the deceased alive on <u>October 27, 19 61</u> , and that death occurred at <u>2:25 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Urshel</u> M.D.		22b. DATE SIGNED <u>27 October 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. URSHEL LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH CRAWLERS & SONS INC., Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>NOV 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



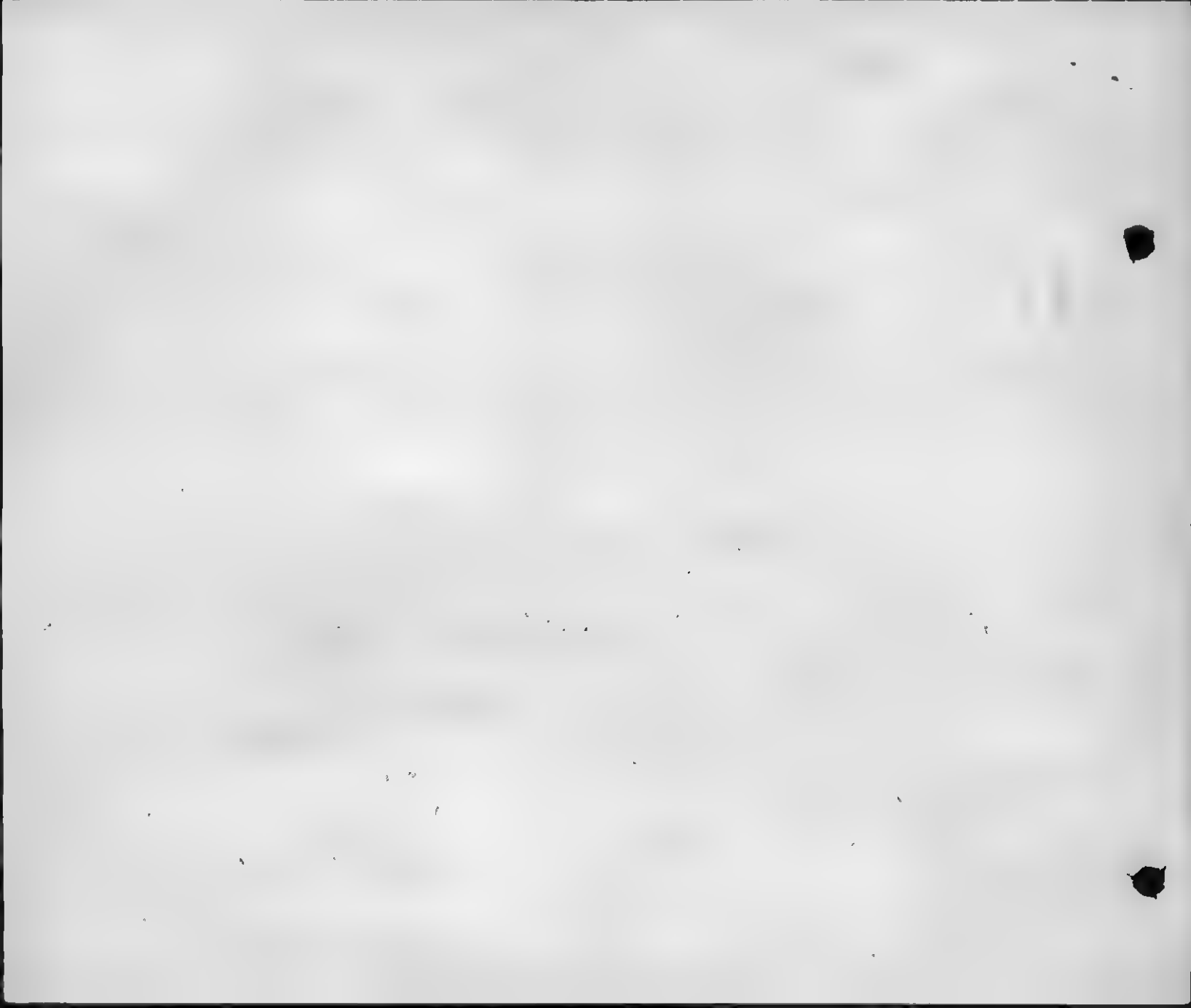
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
11651													
11657													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>					
3. NAME OF DECEASED (Type or print) <u>Rosa M. Padgett</u>				4. DATE OF DEATH <u>Oct. 14 1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/2/77</u>		9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (Country & State, or foreign country) <u>Washington, D.C., U.S.A.</u>					
13. FATHER'S NAME <u>Alfred Richards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Stewart</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT <u>Alice Padgett / As Above</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation, Acute</u> 3 days													
Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Degeneration, chronic</u> 5 yrs +													
(c) <u>Arteriosclerotic Heart Disease</u> 5 yrs +													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>1) Complete Heart Block</u> 2) <u>Chronic Nephrosclerosis</u>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Washington, D.C.</u>		20g. (County) <u>Washington</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Oct 14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 14</u> , 19 <u>61</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Stewart Clapp</u>												22b. DATE SIGNED <u>10-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4740 Chevy Chase Dr</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>													
25a. REC'D BY REGISTRAR DATE <u>OCT 19 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

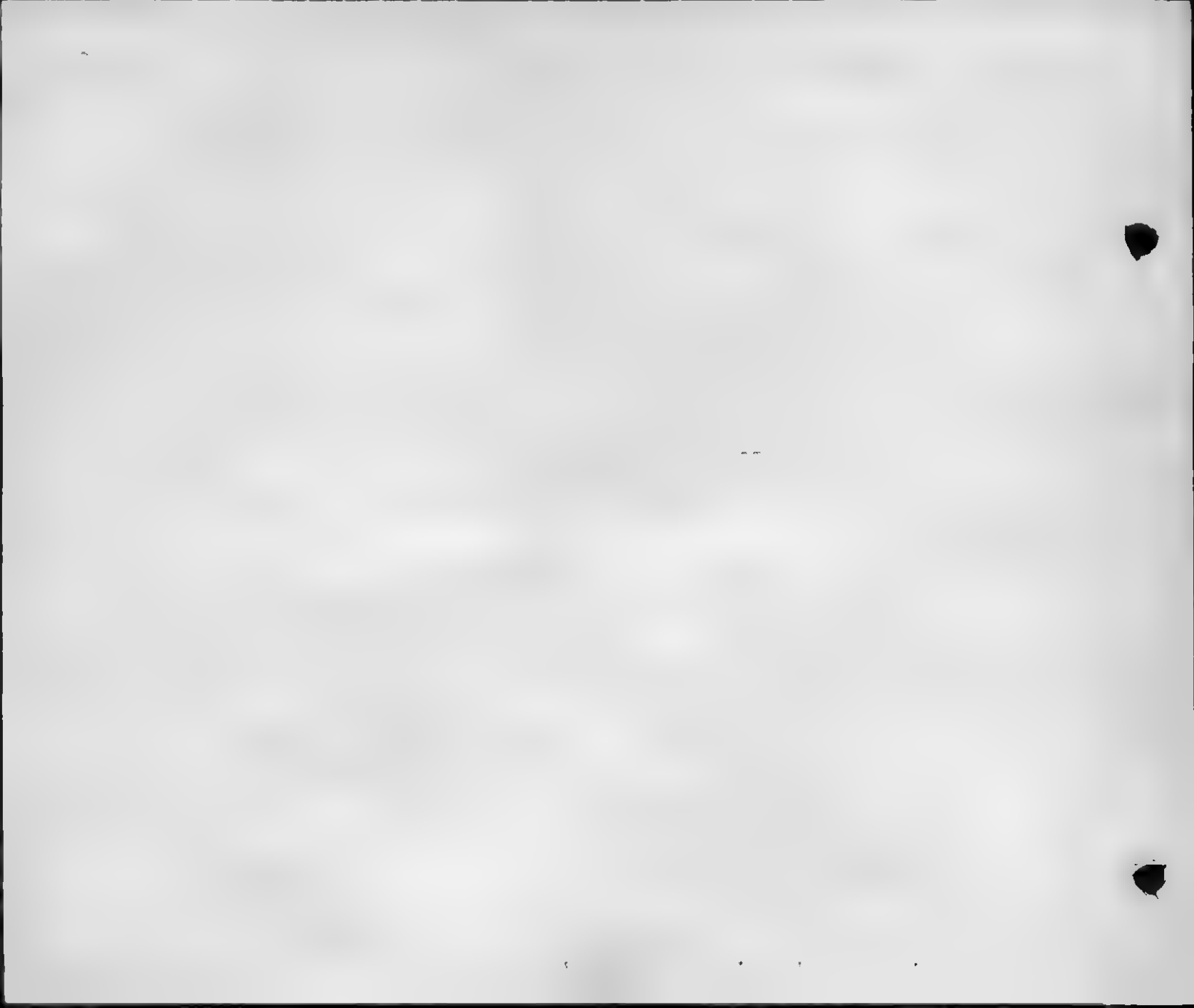
CERTIFICATE OF DEATH

11652

11658

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>MD</u> <u>13</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>12202 Grandview Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maud Stella Parker</u> First Middle Last		4. DATE OF DEATH <u>Oct 8 1961</u> Day Month Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u> <u>10-28-1888</u> 72 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel King</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-9574</u> 17. INFORMANT <u>Welford D. Hudson</u> Address <u>Smy</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.1</u> DUE TO (b) <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>Coronary thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>Sept 25, 1961, to Oct 8, 1961</u>, that (ii) (we) last saw the deceased alive on <u>Oct 8, 1961</u>, and that death occurred at <u>10p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u> 22c. PHYSICIAN'S NAME (Type) <u>Mitchell, George</u>		22b. DATE SIGNED <u>Oct 8 1961</u> 22d. ADDRESS <u>10620 GEORGIA AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince George's, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue</u>		25a. RECD BY REGISTRAR <u>Oct 11 61</u> 25b. REGISTRAR'S SIGNATURE <u>Chas E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

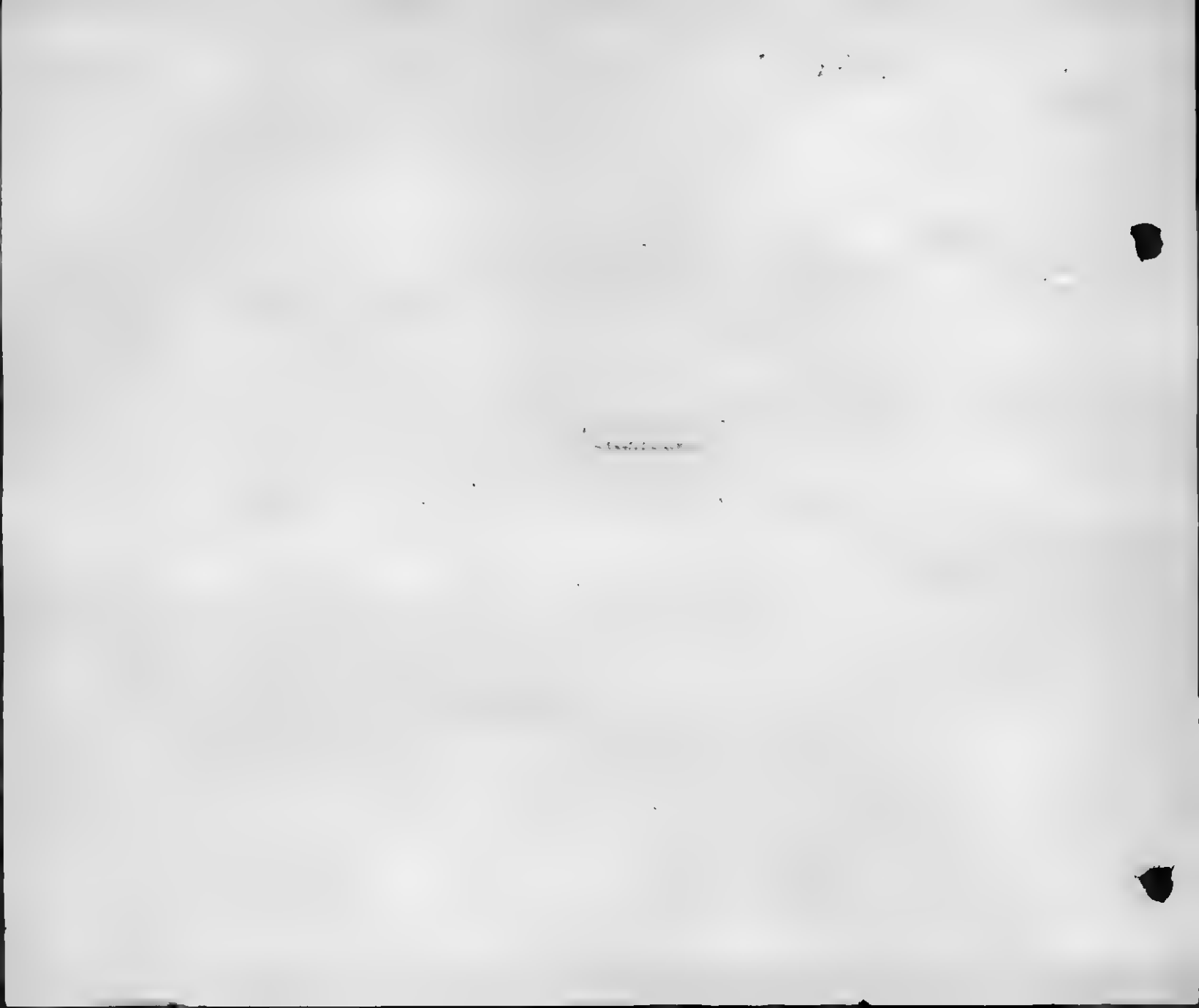
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11653

11653

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>3 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1705 East-West Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rebecca Pearlman</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 15 1889</u> 9. AGE (In years last birthday) <u>72 yrs.</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benzamin Rodman</u>		14. MOTHER'S MAIDEN NAME <u>SARAH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>578-50-3674</u>		17. INFORMANT <u>ALBERT PEARLMAN</u> Address <u>4426 Springdale Sim</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC THROMBOSIS</u> DUE TO (b) <u>Rupture of Myocardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>MYOCARDIAL INFARCT 5-70 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from... 1950, to 10/15, 1961, that (I) (we) last saw the deceased alive on... 10/15, 1961, and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Irving W. Wink</u>		22b. DATE SIGNED <u>10/16/61</u>	22c. PHYSICIAN'S NAME (Type) <u>Irving W. Wink</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>
23d. LOCATION (City, town or county) <u>Hyattsville, Md.</u>		23e. (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick J. ...</u>		25a. REC'D BY REGISTRAR <u>—</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>
25c. ADDRESS <u>4207-9th St NW</u>		25d. DATE <u>OCT 18 '61</u>	25e. REGISTRAR'S SIGNATURE <u>—</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

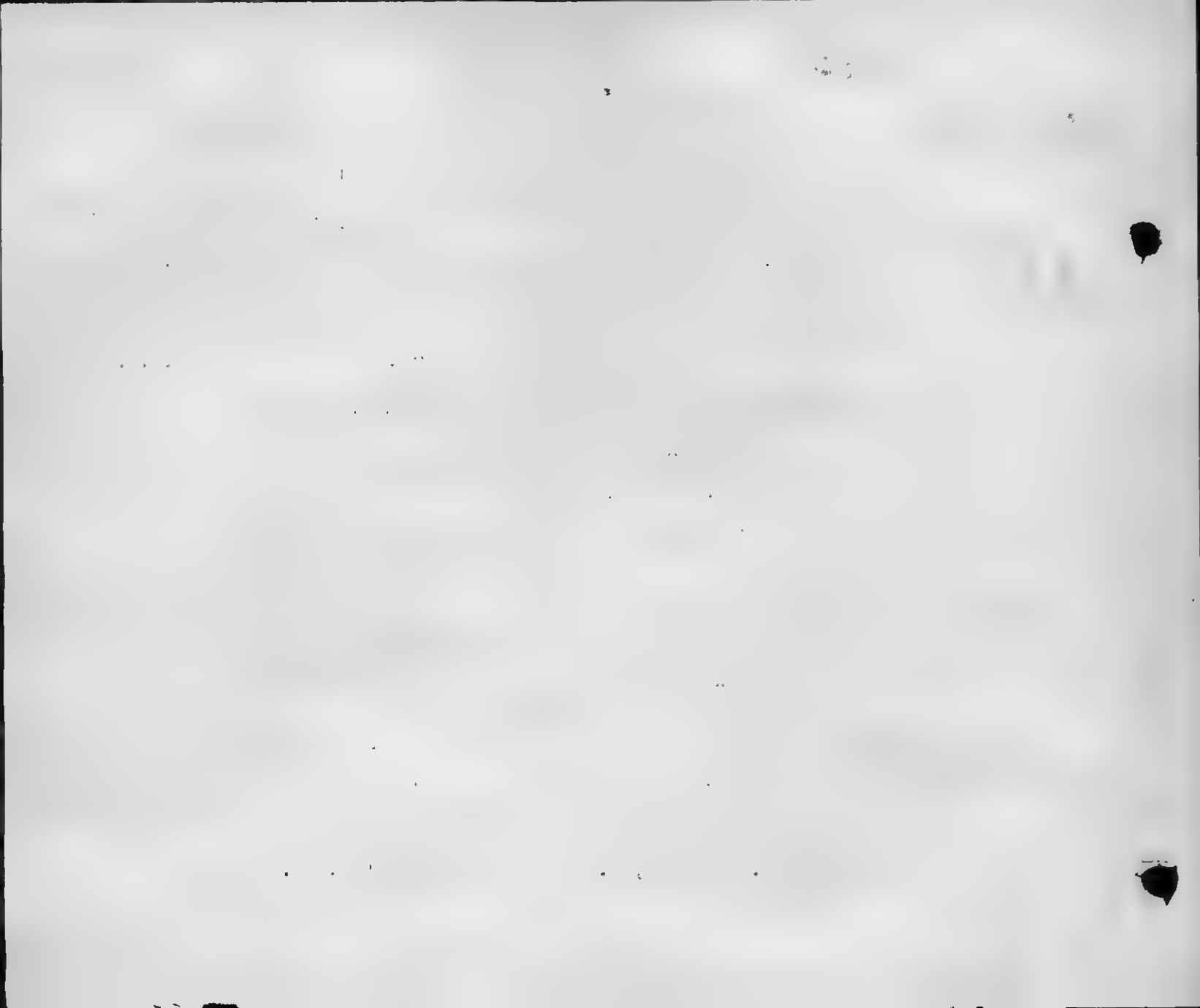
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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11654 CERTIFICATE OF DEATH 11640											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>OLNEY</u> c. LENGTH OF STAY IN 1b <u>29 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>WEST FRIENDSHIP</u> d. STREET ADDRESS <u>PFEFFERKORN ROAD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>SAMUEL LOUIS PFEFFERKORN</u>				4. DATE OF DEATH <u>10 16 19 61</u>				9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX <u>MALE</u>				6. COLOR OR RACE <u>WHITE</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/3/1896</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COFFEE MERCHANT</u>				11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>ALBERT PFEFFERKORN</u>				14. MOTHER'S MAIDEN NAME <u>CECELIA EINSTIEN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>12011</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Dark urinary retention due to prostatic hypertrophy</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVA. BETWEEN ONSET AND DEATH <u>24 hrs 5 days</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>				20f. (City or town) (County) (State) <u>-</u>			
21. I certify that (I) (<u>this hospital</u>) attended the deceased from. <u>9/17</u> 19 <u>61</u> to <u>10/16</u> 19 <u>61</u> , that (I) (<u>first</u>) last saw the deceased alive on <u>OCTOBER 16</u> 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles S. Whitaker</u>				22b. DATE SIGNED <u>10-17-61</u>				22c. PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>			
22d. ADDRESS <u>CLARKSVILLE, MD.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10-19-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>				23d. LOCATION (City, town or county) (State) <u>ELLICOTT CITY Md.</u>				23e. REC'D BY REGISTRAR <u>FC. HIGINBOTHOM</u>			
23f. REGISTRAR'S SIGNATURE <u>FC. HIGINBOTHOM</u>				23g. ADDRESS <u>ELLICOTT CITY Md</u>				23h. DATE <u>OCT 19 '61</u>			



within 24 hours after

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11655

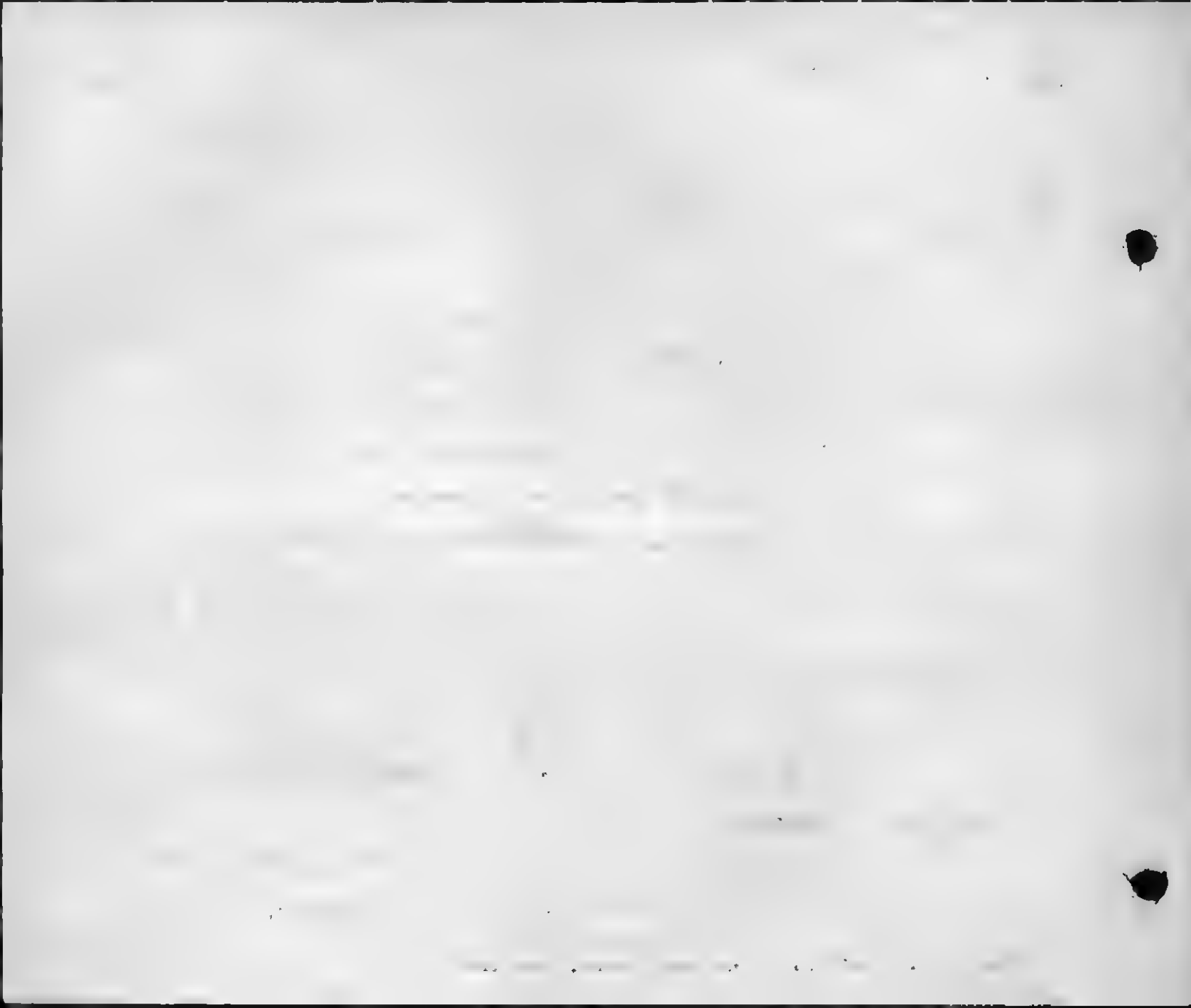
11641

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>2 hrs. 15 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10605 Bucknell Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Sina Jennie Pike</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 17, 1870</u>	9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Holland</u>
13. FATHER'S NAME <u>M. Brunswick</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cowell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Hypertensive + Arteriosclerotic Heart Disease long duration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>long duration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 4 hours</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>Oct. 20</u> 1961 , that (I) (we) last saw the deceased alive on <u>Dec. 20</u> 1961 , and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Isaacson</u>		22b. DATE SIGNED <u>10/20/61</u>	22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		23b. DATE THEREOF <u>10/24/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Wiska</u>		25a. REC'D BY REGISTRAR <u>OCT 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>	
25d. LOCATION (City, town or county) <u>Rochester, New York</u>		25e. (State)	

(M)

(I)

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

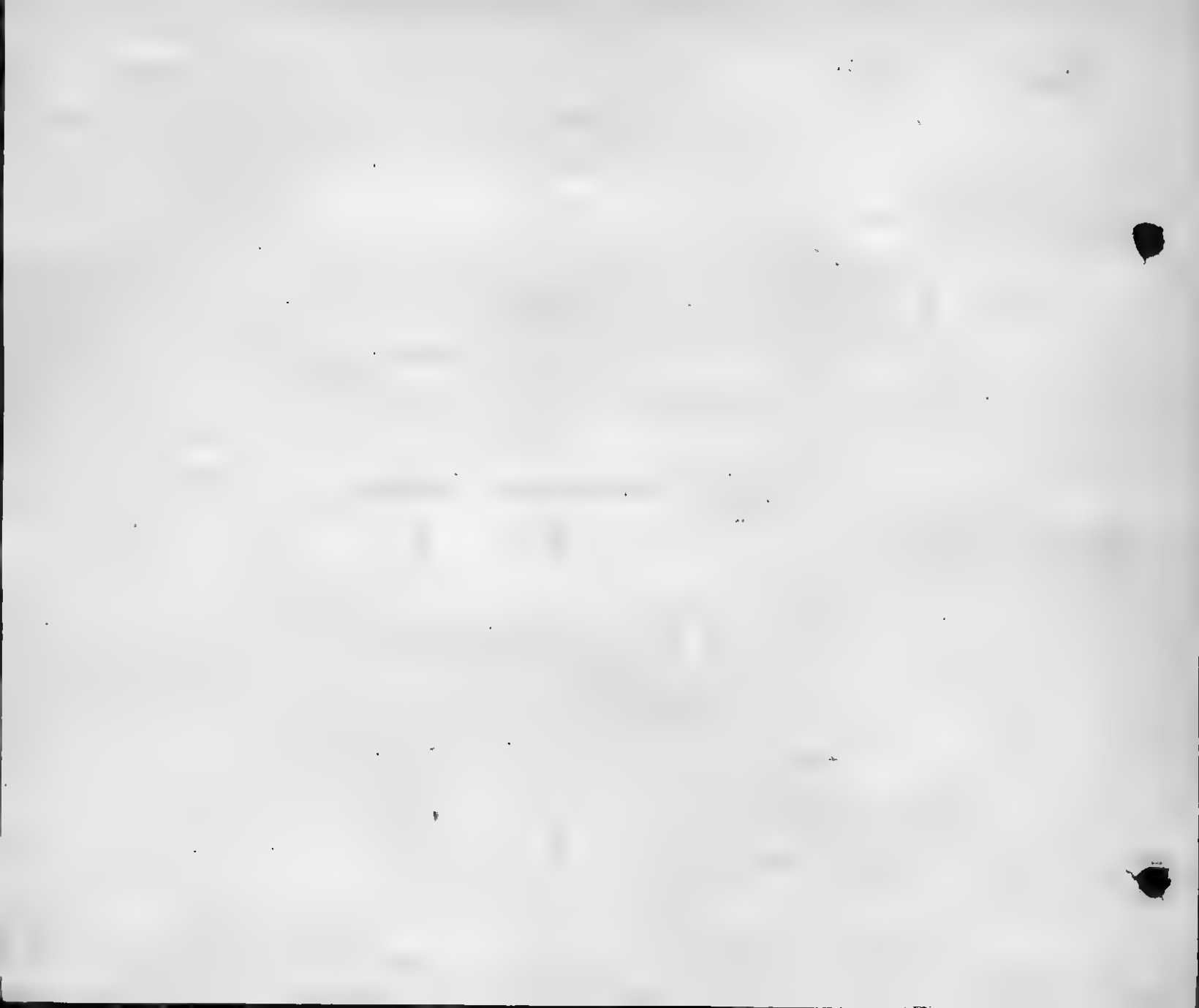
11656

CERTIFICATE OF DEATH

11642

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside of corporate limits, give RURAL and give nearest town) Silver Spring, Md.
c. LENGTH OF STAY IN IL 4 1/2 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Pvt. home of daughter (Mrs. Nellie Peter)
e. NAME OF DECEASED (Type or print) Laura Ellen Poole
f. SEX Female
g. COLOR OR RACE Caucasian
h. MARIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐
i. DATE OF BIRTH 10-9-81
j. AGE (In years last birthday) 79
k. IF UNDER 1 YEAR Months 10 Days 2 Year 1961
l. IF UNDER 24 HRS. Hours 10 Min. 2
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
n. 10b. KIND OF BUSINESS OR INDUSTRY Farming
o. BIRTHPLACE (County & State or foreign country) Prossville, Md.
p. CITIZEN OF WHAT COUNTRY? U.S.A.
q. FATHER'S NAME Thomas Jefferson Reed
r. MOTHER'S MAIDEN NAME Hattie Norris
s. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐
t. SOCIAL SECURITY NO. 10-2-1961
u. INFORMANT William C. Helton
v. ADDRESS Baltimore, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
a. IMMEDIATE CAUSE (a) Acute Mesenteric Occlusion
b. Generalized Arteriosclerosis
c. Senility
d. DUE TO Acute thrombosis Rt. Popliteal Artery.
e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute thrombosis Rt. Popliteal Artery.
f. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
g. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
h. TIME OF INJURY Month, Day, Year 11-11-1957
i. INJURY OCCURRED While at work
j. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
k. (City or town) Prossville (County) Montgomery (State) Md.
l. I certify that (I) (the hospital) attended the deceased from 11-11-1957 to 10-2-1961, that (I) (the) last saw the deceased alive on 10-2-1961, and that death occurred at 5:00 P.M. from the causes and on the date stated above.
m. SIGNATURE N.C. Shoemaker M.D.
n. PHYSICIAN'S NAME (Type) N.C. Shoemaker M.D.
o. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
p. ADDRESS 8045 Woodbury Dr. Silver Spring Md.
q. DATE SIGNED 10-2-1961
r. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
s. DATE THEREOF 10/5/61
t. NAME OF CEMETERY OR CREMATORY MONTEAGUE CEMETERY
u. LOCATION (City, town or county) Bethesda (State) Md.
v. FUNERAL DIRECTOR'S SIGNATURE William C. Helton
w. ADDRESS Baltimore, Md.
x. REC'D BY REGISTRAR 10-5-61
y. REGISTRAR'S SIGNATURE William C. Helton



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MARYLAND STATE DEPARTMENT OF HEALTH

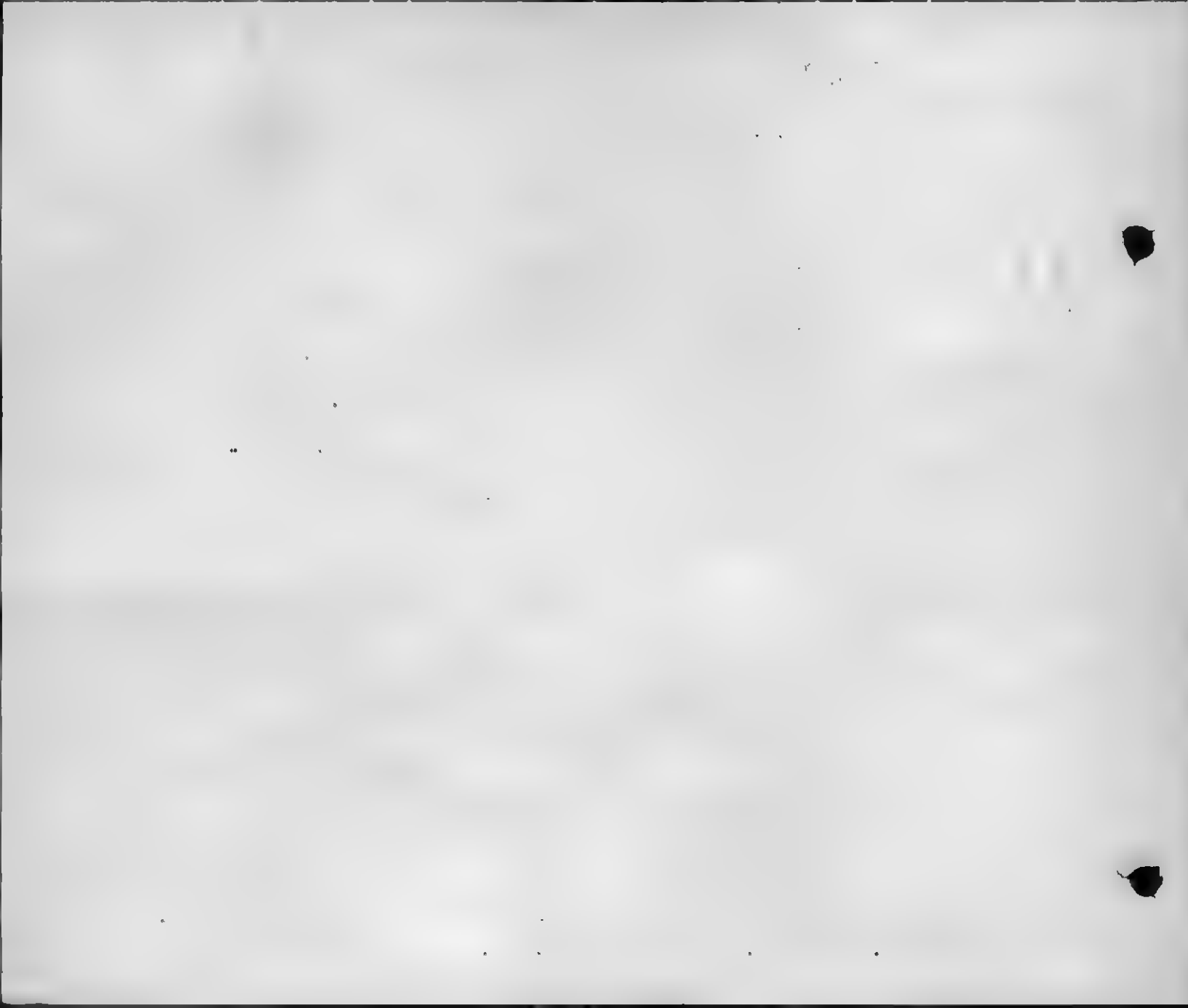
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11657

11643

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN IL <u>41,rs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 DeSellum St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>15 DeSellum St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Middleton Pope</u> 5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>June 11, 1903</u> 9. AGE (In years last birthday) <u>58 yrs.</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> IF UNDER 24 HRS Hours <u></u> Min. <u></u>		4. DATE OF DEATH <u>Oct 17th 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret-Store Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Med,</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Pope</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Virginia D. Pope, As No 2</u>		14. MOTHER'S MAIDEN NAME <u>Annie V. Stephens</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, STOMACH WITH METASTASES, LIVER</u> (b) <u>151X</u> DUE TO <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1961</u> to <u>Oct 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 13, 1961</u> , and that death occurred on <u>Oct 17, 1961</u> , from the causes and on the date stated above 22a. SIGNATURE <u>Philip R. James</u> 22b. DATE SIGNED <u>10:30 PM</u> 22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u> 22d. ADDRESS <u>WASHINGTON CLINIC, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>10-20-61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u> ADDRESS <u>Gaithersburg, Md.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Cemetery</u> 23d. LOCATION (City, town or county) <u>Damascus, Md.</u> (State) <u></u> 25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>William S. House</u> DATE <u>OCT 20 1961</u>	



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

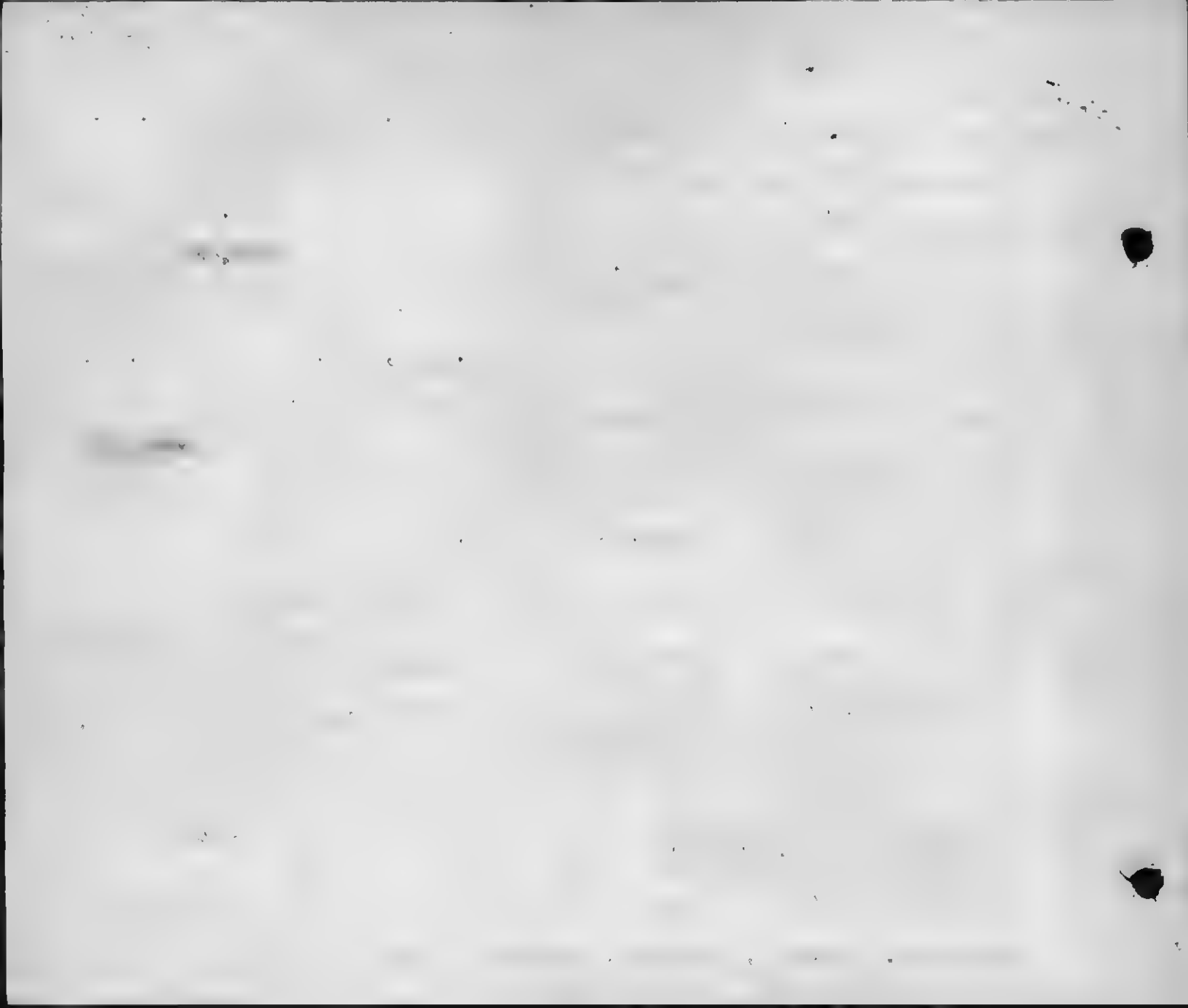
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11644

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 43 Glen Echo Heights d. STREET ADDRESS 6216-Walbonding Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charlotte W. Potter		4. DATE OF DEATH October 1 1961		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1889	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) St. Paul, Minn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Waugh		14. MOTHER'S MAIDEN NAME Charlotte Crutchett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Virginia Potter (daughter in law)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left femur DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 week		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH, <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home fracturing left hip			
20c. TIME OF INJURY Month, Day, Year 2:45 P.M. 9/23/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Glen Echo Hts		20g. (County) Montg		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/2/61	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/3/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or country) Suitland, Maryland		22e. (State) Md.			
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR OCT 4 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

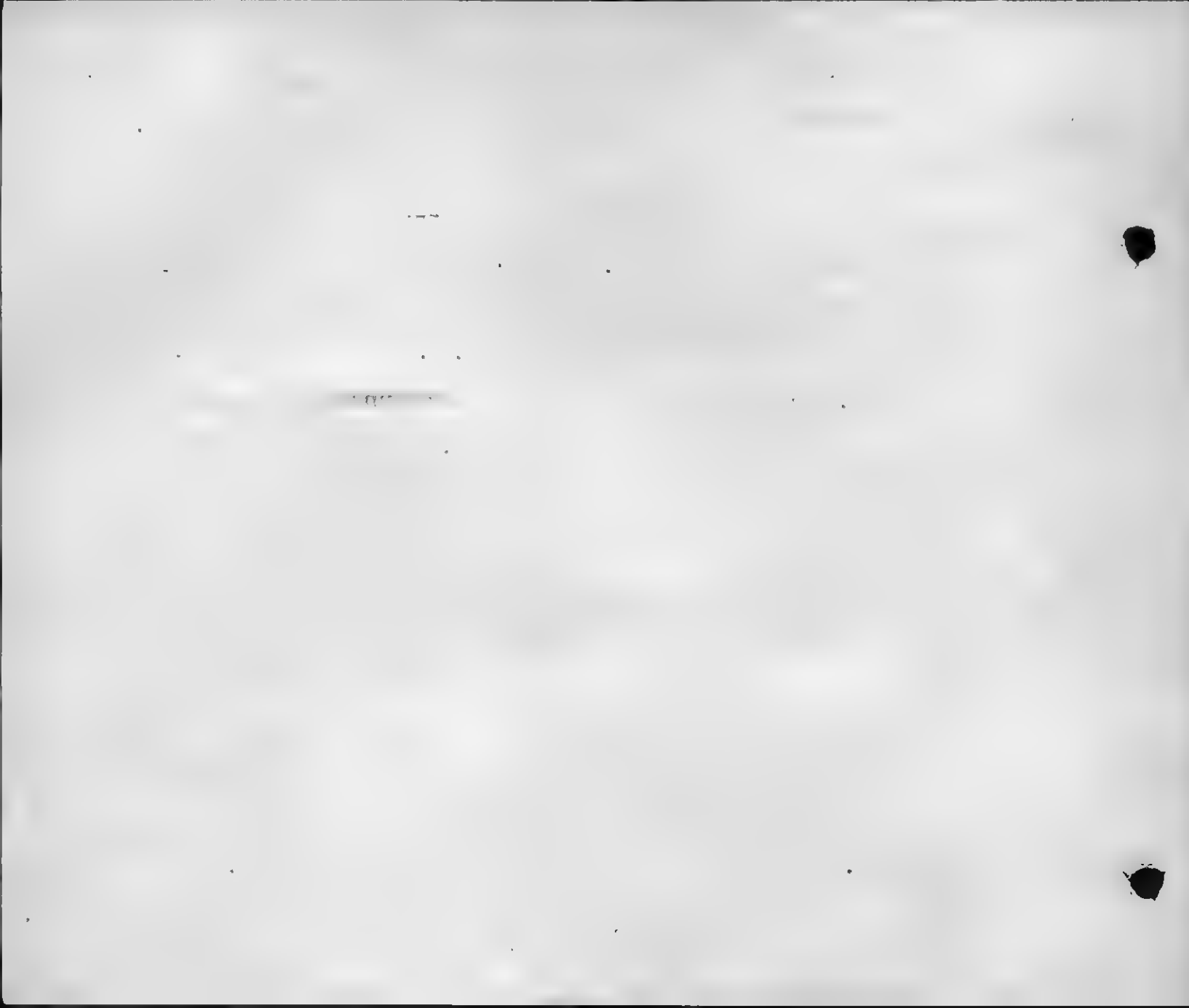


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received by the hospital or attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11659 Items 13 & 14 film 4-97 10/11/61 ink 11645										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if inst tuitions Residence before admision) e. STATE Maryland b. COUNTY Mont.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Minette B. Prigg			4. DATE OF DEATH 10 3 19 61							
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1/24/99	
9. AGE (In years last birthday) 62 yrs.			IF UNDER 1 R. IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE Country & State, or foreign country D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Burton Bergmann			14. MOTHER'S MAIDEN NAME Helena Kunzig Bergmann							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO no			17. INFORMANT William B. Prigg, husband same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			INTERVAL BETWEEN ONSET AND DEATH 24 hrs							
PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. + x DUE TO Condition which gave rise to immediate cause (e), stating the underlying cause last DUE TO carcinoma of the stomach toxicity, peritonitis advanced carcinomatosis										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9:26 a.m. 19 10 to 10:35 a.m. 19 10 , that (I) (we) last saw the deceased alive on 10/6/61 19 10 , and that death occurred at 10:35 a.m. from the causes and on the date stated above.										
22a. SIGNATURE John O. Robben			22b. DATE 10/6/61			22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			22d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/6/61			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Sheila M. Co. Wash D.C.			25a. REC'D BY REGISTRAR OCT 5 '61			25b. REGISTRAR'S SIGNATURE Arthur L. Kraus				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11660

11646

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>3048 Buchanan St., Apt. A2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Lawrence Ramsey</u> f. SEX <u>Male</u> g. COLOR OR RACE <u>Caucasian</u> h. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. DATE OF BIRTH <u>April 25, 1889</u> j. AGE (in years last birthday) <u>72 yrs.</u> k. IF UNDER 1 YEAR Months Days l. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>October 24, 1961</u> m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVY WWI</u> n. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> o. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lodwick Ramsey</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Blankenship</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. 17. INFORMANT WIFE: Mrs. Marion Ramsey, s me as <u>12</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>September 25, 1961</u> to <u>October 24, 1961</u> , that (s) (we) last saw the deceased alive on <u>October 24, 1961</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James L. Beeby</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>JAMES L. BEEBY LT MC USN</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 27, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fair View Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Roanoke, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home</u> ADDRESS <u>816 H St. NE, Washington, D.C.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 26 '61</u> <u>Arthur L. H...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

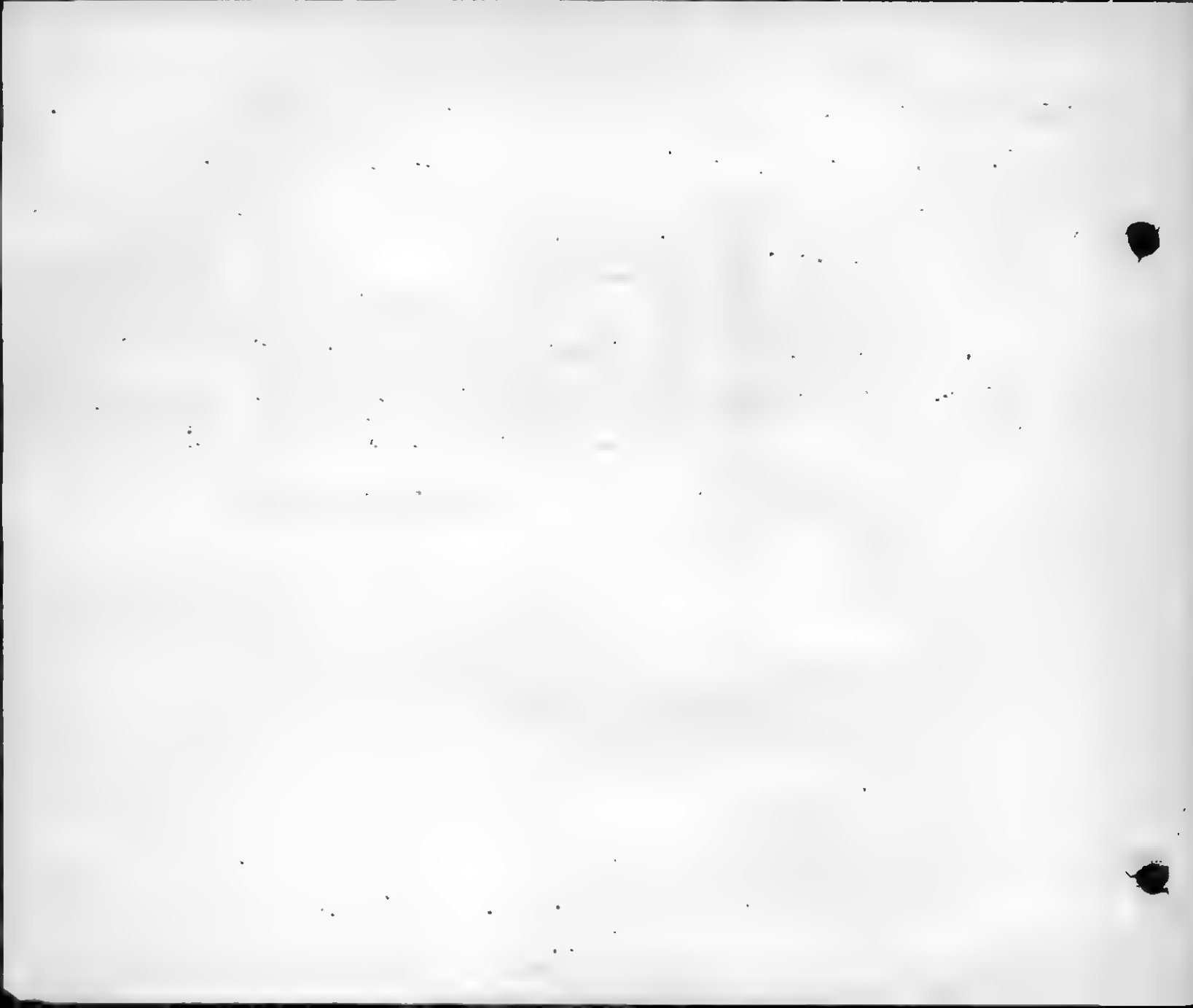
Reg. Dist. No. 11647

11661

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hungerford Town, Rockville</u>		c. LENGTH OF STAY IN lb. <u>1 Year</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hungerford Town, Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#3 - Brothers Court</u>		d. STREET ADDRESS <u>#3 - Brothers Court</u>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>W.</u> Middle <u>Reed</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Godfrey</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Donaldson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Mrs. Helma R. Dunn</u> Address <u>above</u>		Relationship <u>Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Family</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/15</u> , 19 <u>61</u> , to <u>10/31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>61</u> , and that death occurred at <u>7:00</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Earl W. Traceff</u> M.D. <u>1716 Windsor Place</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. TRACEFF, M.D.</u>		<u>11 H. W. Hill, Ave.</u>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 3/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Belmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malloy's Funeral Home - 714d</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Howe</u>	24b. REGISTRAR'S SIGNATURE
DATE <u>NOV 6 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11662

11648

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b. 43 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville d. STREET ADDRESS 1596 Lancaster Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella Aston Rhodes		4. DATE OF DEATH October 23 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1903
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Aston		14. MOTHER'S MAIDEN NAME Elizabeth Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. HUS: William K. Rhodes, same as #2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Carcinoma of the lungs with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) and pleural effusion - malignant		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from September 11 19 61 to October 23 19 61 , that (I) (we) last saw the deceased alive on October 23 19 61 , and that death occurred at 12:57 PM from the causes and on the date stated above.	
22a. SIGNATURE B. M. SHEPARD	22b. DATE SIGNED 24 October 1961
22c. PHYSICIAN'S NAME (Type) B. M. SHEPARD LT MC USN	22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Oct 25 1961	23c. NAME OF CEMETERY OR CREMATORY Ceder Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR OCT 26 '61	25b. REGISTRAR'S SIGNATURE Arthur J. Harris



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

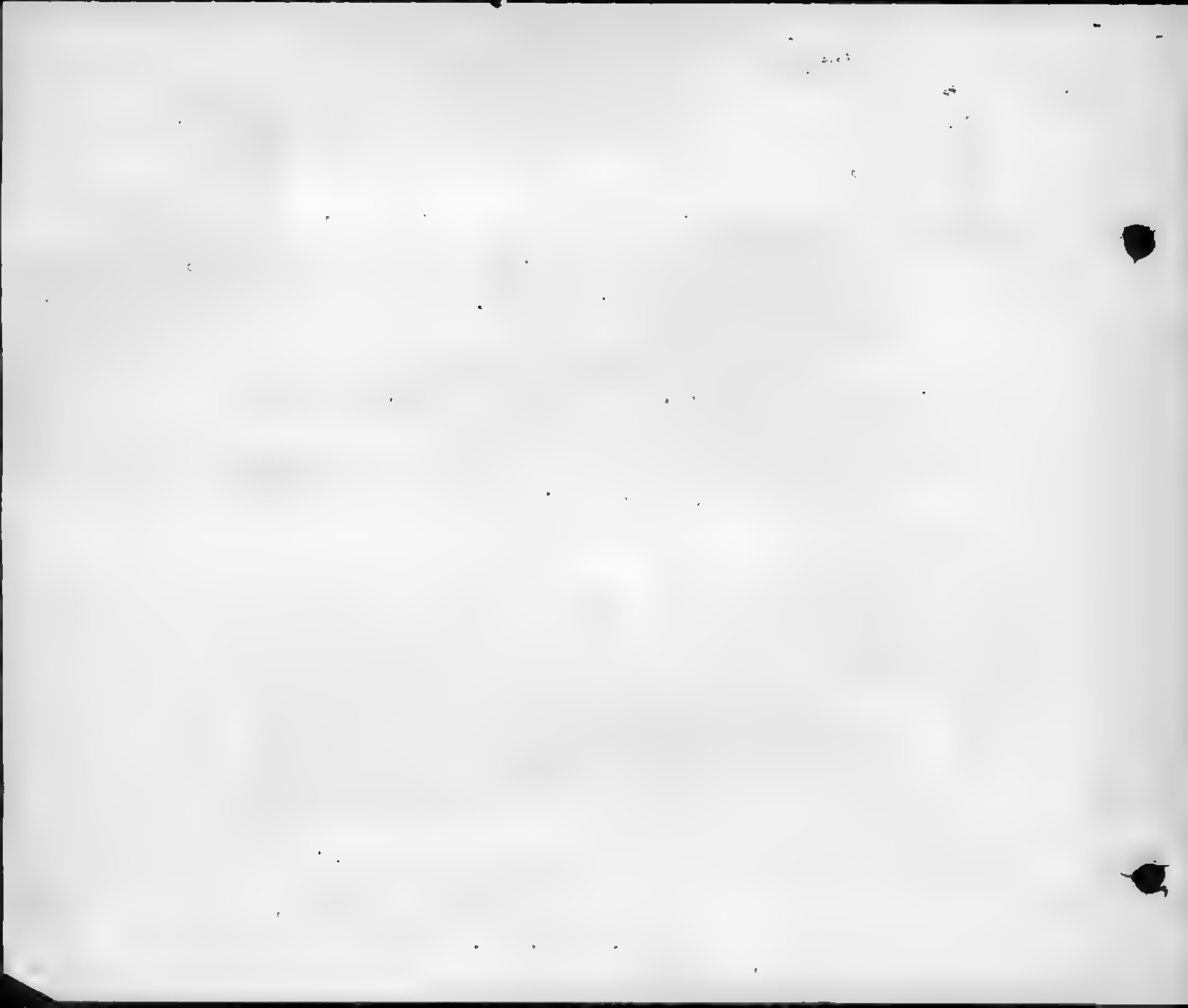
11663

11640

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				d. STREET ADDRESS 11302 Dewey Road,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Robin Dale				4. DATE OF DEATH October 7, 1961			
First Middle Last				Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7, 1961	
						9. AGE (In years last birthday) yrs. 9 Months 32 Days 9 Hours 32 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Thomas Brown Rhodes, Jr.				14. MOTHER'S MAIDEN NAME Helen Carol Argenbright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO no		17. INFORMANT father	
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TWIN BIRTH - HYALINE MEMBRANE 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/7/61 to 10/7/61 , that (I) (we) last saw the deceased alive on 10/7/61 , and that death occurred at 9:45 M, from the causes and on the date stated above							
22a. SIGNATURE Dr. Herbert H. Diamond				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) HERBERT H. DIAMOND				22d. ADDRESS 911-SILVER SPRING AVE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia MD	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland				25a. REC'D BY REGISTRAR DATE OCT 13 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO LOCAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11664

11650

Item 9 filled in 10/20/61 ink

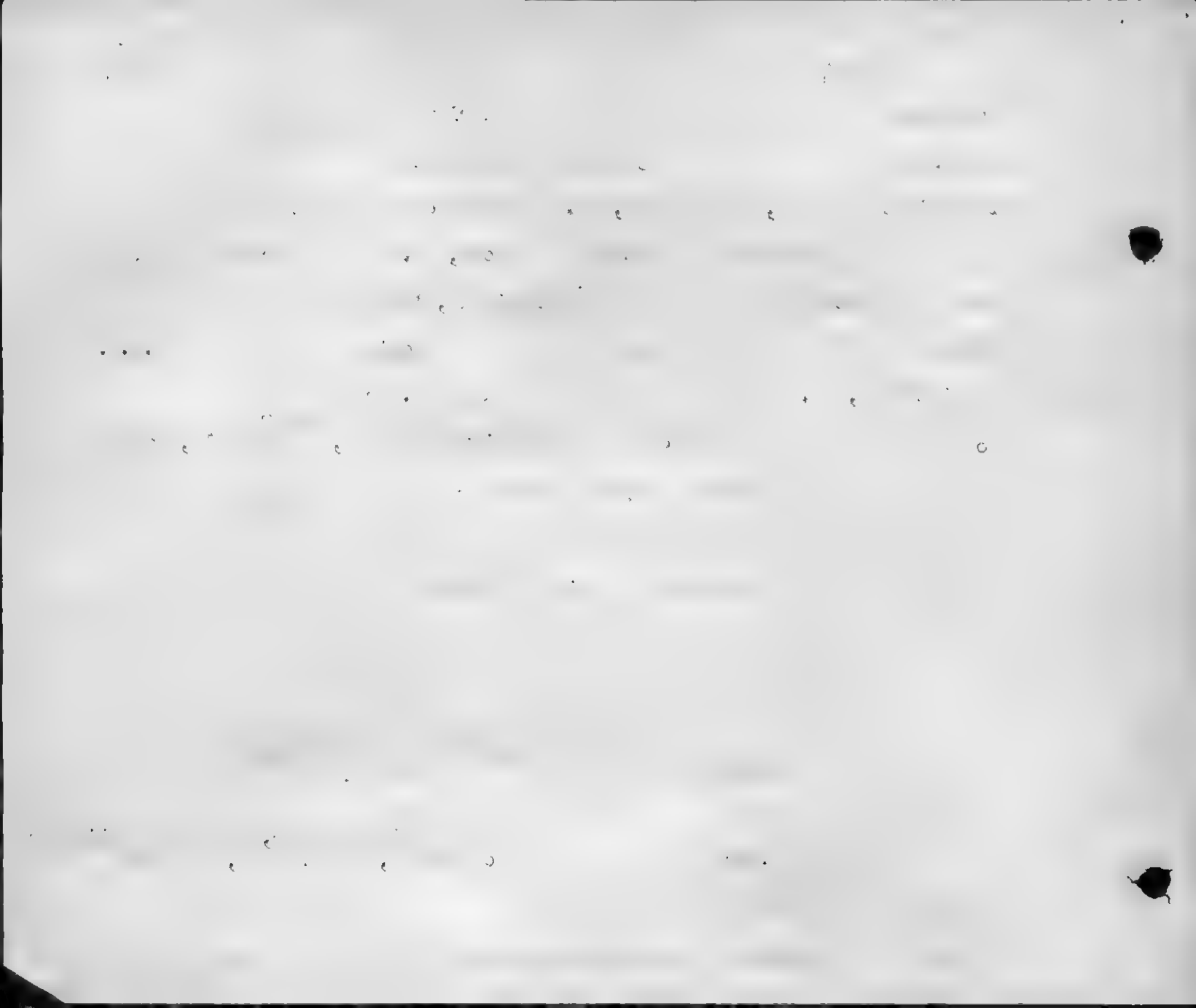
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>8007 Flower Avenue</u>				d. STREET ADDRESS <u>8007-Flower Ave-Takoma</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>RIFE</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-29-1875</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>13</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker -</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernestine Theodore Rife</u>				14. MOTHER'S MAIDEN NAME <u>Barbara H. Rife</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>420-1</u>		17. INFORMANT <u>Mrs. Edna J. Giroux</u>		Address <u>8009-Flower Ave-Takoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) <u>Coronary Heart Disease</u> DUE TO <u>Arteriosclerosis, Generalized</u> (c) <u>10 yrs</u> <u>15 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>13 Oct</u> , 1961, that (I) (we) last saw the deceased alive on <u>13 Oct</u> , 1961, and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above							
22a. SIGNATURE <u>M. B. Queen</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>13 Oct 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		22d. ADDRESS <u>7112 Willow Ave Takoma Park, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Riggs Road-Pinecroft</u>		23d. LOCATION (City, town, or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Reisterstown Rd</u>		25a. RECEIVED BY REGISTRAR <u>DATE OCT 16 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	



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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11665
11651
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 31 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Florida c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pensacola d. STREET ADDRESS 2005 North 8th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First (None) Middle Ross, Jr. Last		4. DATE OF DEATH October 18, 1961 Month October Day 18, Year 19 61	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1948 Last 13 Month 13 Day 13 Year 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (County & State, or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Ross, Sr.		14. MOTHER'S MAIDEN NAME Hattie M. Grier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. WHERE DECEASED The Clinical Center, Bethesda 14, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute glomerulonephritis Uremia Anemia Acidosis Hyperkalemia 3 months 13 years ? DUE TO (b) Pulmonic Stenosis DUE TO (c) Hypergammaglobulinemia, marrow plasmocytosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 13 years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 19	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19		20g. (County) 19	
20h. (State) 19			
21. I certify that (X) (this hospital) attended the deceased from 17 September 19 61 to 18 October, 19 61 that (X) (we) last saw the deceased alive on 17 October 19 61 and that death occurred 1:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Adler		22b. DATE SIGNED 18 October 1961	
22c. PHYSICIAN'S NAME (Type) Richard C. Adler		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61	
23c. NAME OF CEMETERY OR CREMATORY Pensacola		23d. LOCATION (City, town or county) Florida	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Jenkins		25a. REC'D BY REGISTRAR OCT 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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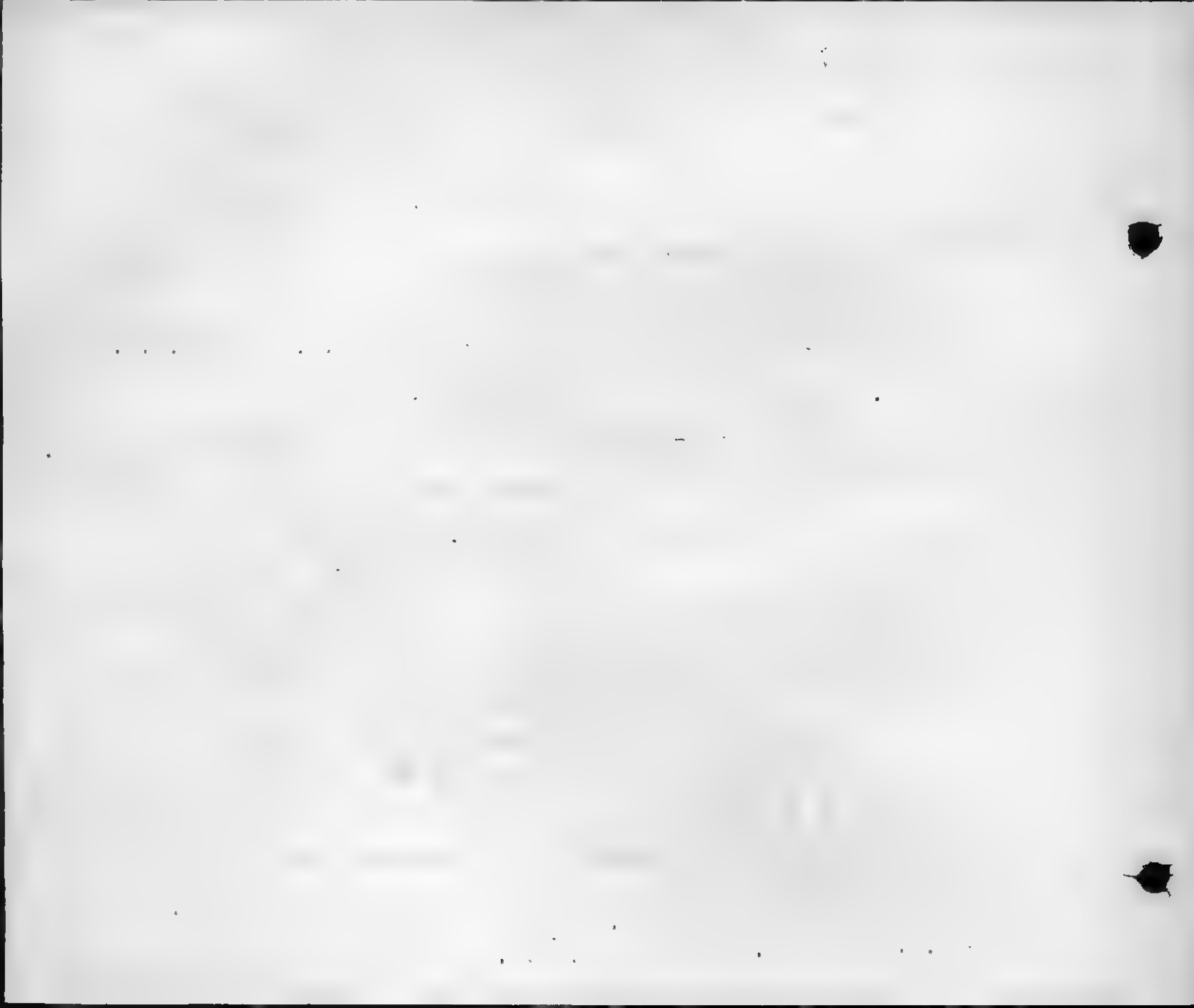
VR A15 (4)
15M 9/59

11666

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11652

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9411 Garwood Street		d. STREET ADDRESS 9411 Garwood Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle LOUISE Last ROWZEE		4. DATE OF DEATH Month 10 Day 20 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1885
9. AGE (in years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 76 Days 20 Hours 10 Min 10	
10a. JSUAL. OCCUPATION (Give kind of work done during most of working life, even if retired) Finance Office-- War Department		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward G. Rowzee		14. MOTHER'S MAIDEN NAME Estelle Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-32-3288	
17. INFORMANT Miss Blanche Rowzee		Address 9411 Garwood Street, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 44-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic DUE TO Vascular disease (c) 072 hrs INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 to Oct 20, 1961 , that (I) (we) last saw the deceased alive on 10/19 19 61 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 10/20/61	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIV. BLVD. S.E., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/23/61	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.		25a. REC'D BY REGISTRAR OCT 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11653

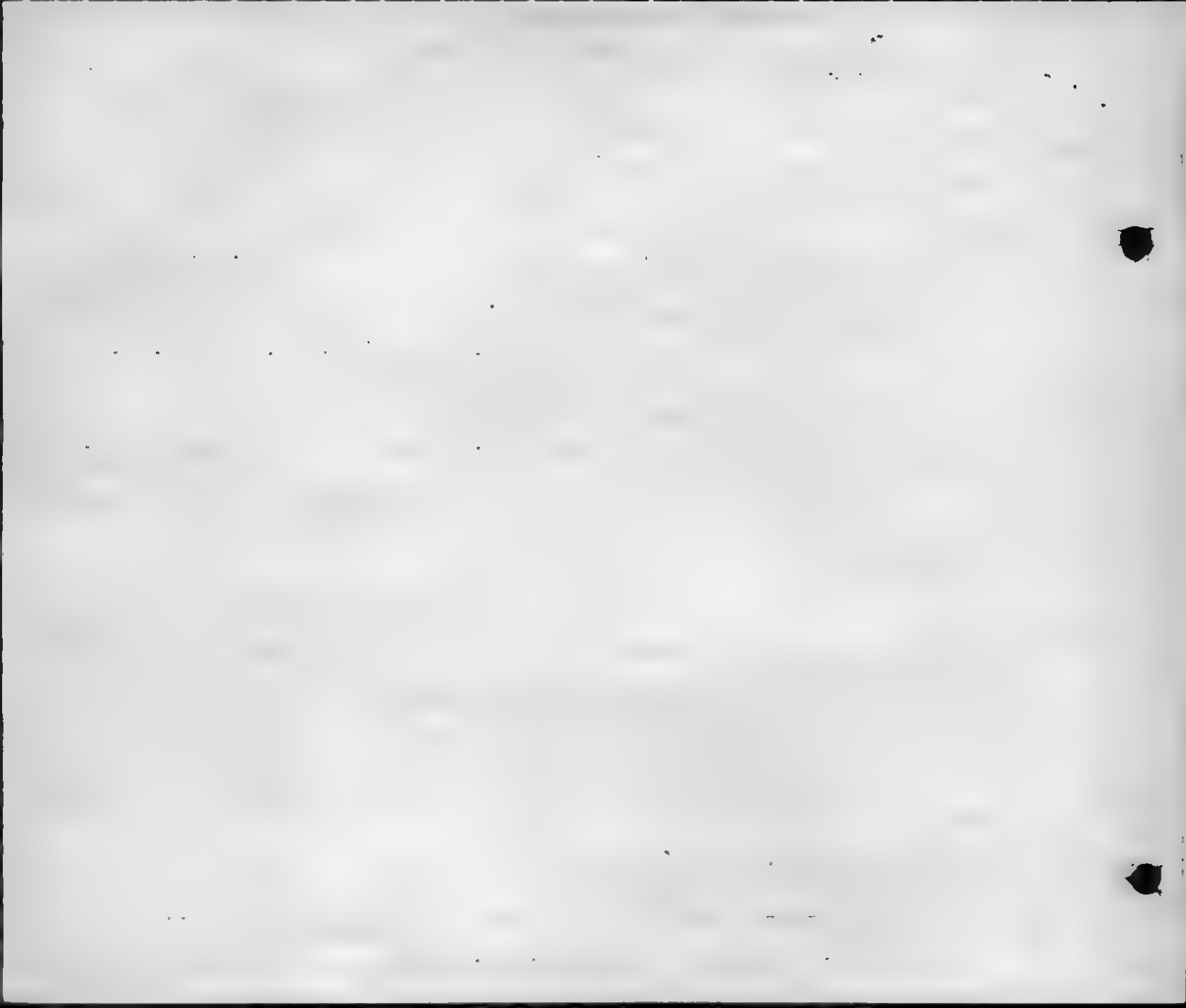
11667

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b 12 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 Falls Road		e. STREET ADDRESS 224 Falls Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Ryan		4. DATE OF DEATH Month Oct. Day 7, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1875
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 7 Days 9	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Ft. Washington, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Ward		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Son John E. Ryan		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Coronary of right heart DUE TO with generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) (no surgery) DUE TO DUE TO 			INTERVAL BETWEEN ONSET AND DEATH 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1961 to October 7, 1961 , that I last saw the deceased alive on Oct-7 , 1961, and that death occurred at 11:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Linthicum		ADDRESS (Street, city or town, state) 110 S. Washington St. Rockville, Md.	
DATE SIGNED 10/7/61			
PHYSICIAN'S NAME (Type) William A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-10-61	22c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery	22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR OCT 13 '61		24b. REGISTRAR'S SIGNATURE Robert S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

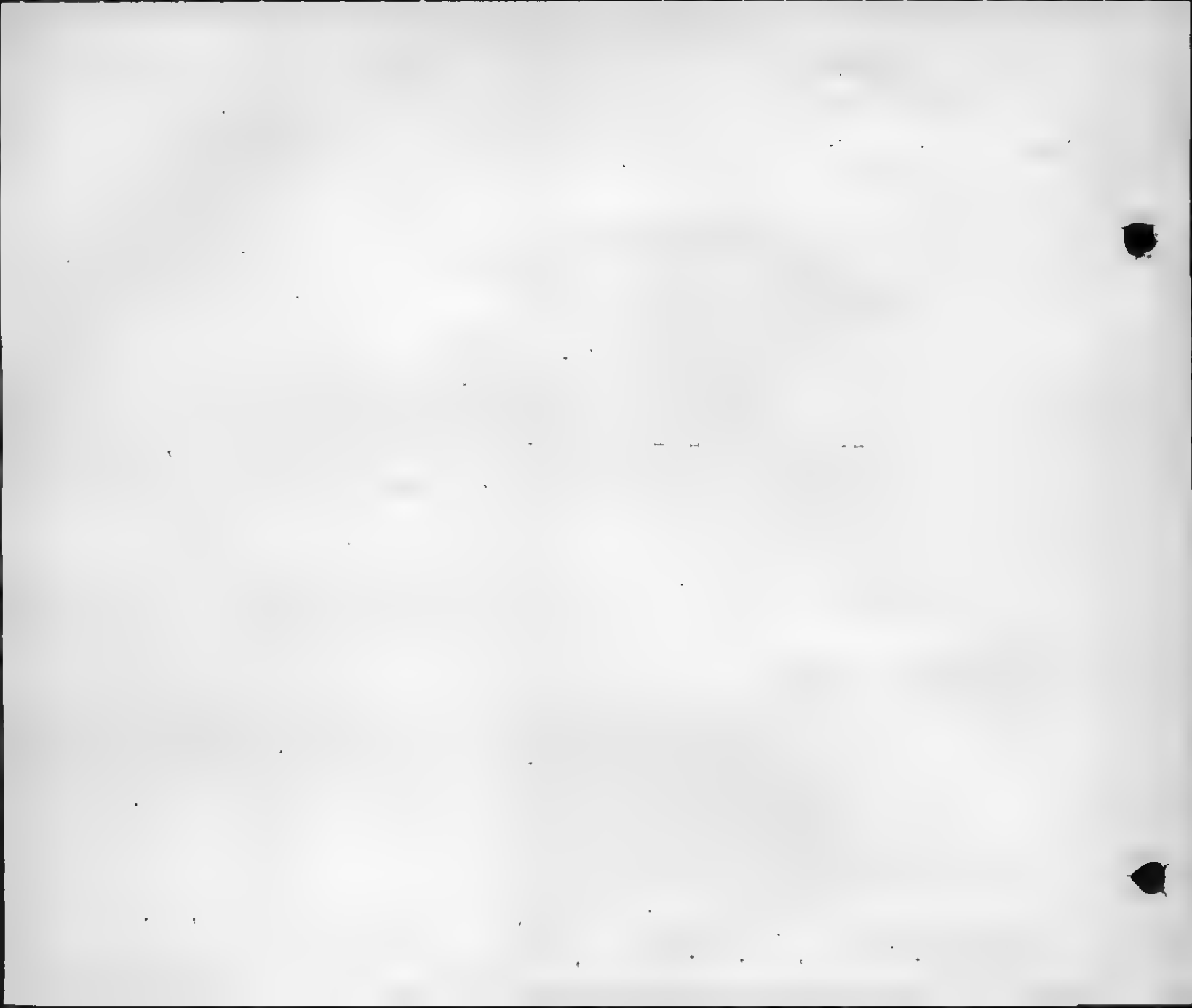
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11668

11654

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest city or town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grubb Road</u>		d. STREET ADDRESS <u>8523 Grubb Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Sacher</u> Last <u>Sacher</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1871</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hat finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miller Hat Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Blender Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Sacher</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Sacher</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>201-07-6584</u>		17. INFORMANT <u>Mrs. Florence Sindell</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>10-1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Aneurysm and Aortic Regurgitation</u> DUE TO <u>15 years</u> (c) <u>Atherosclerosis</u> DUE TO <u>4 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from <u>October 1956</u> to <u>October 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1961</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Robert B. Havell MD</u>		22b. DATE SIGNED <u>10-31-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>		22d. ADDRESS <u>5576 Neb. Ave - DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sinking Springs, Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sinking Springs, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>		25c. ADDRESS <u>8434 Georgia Avenue</u>	

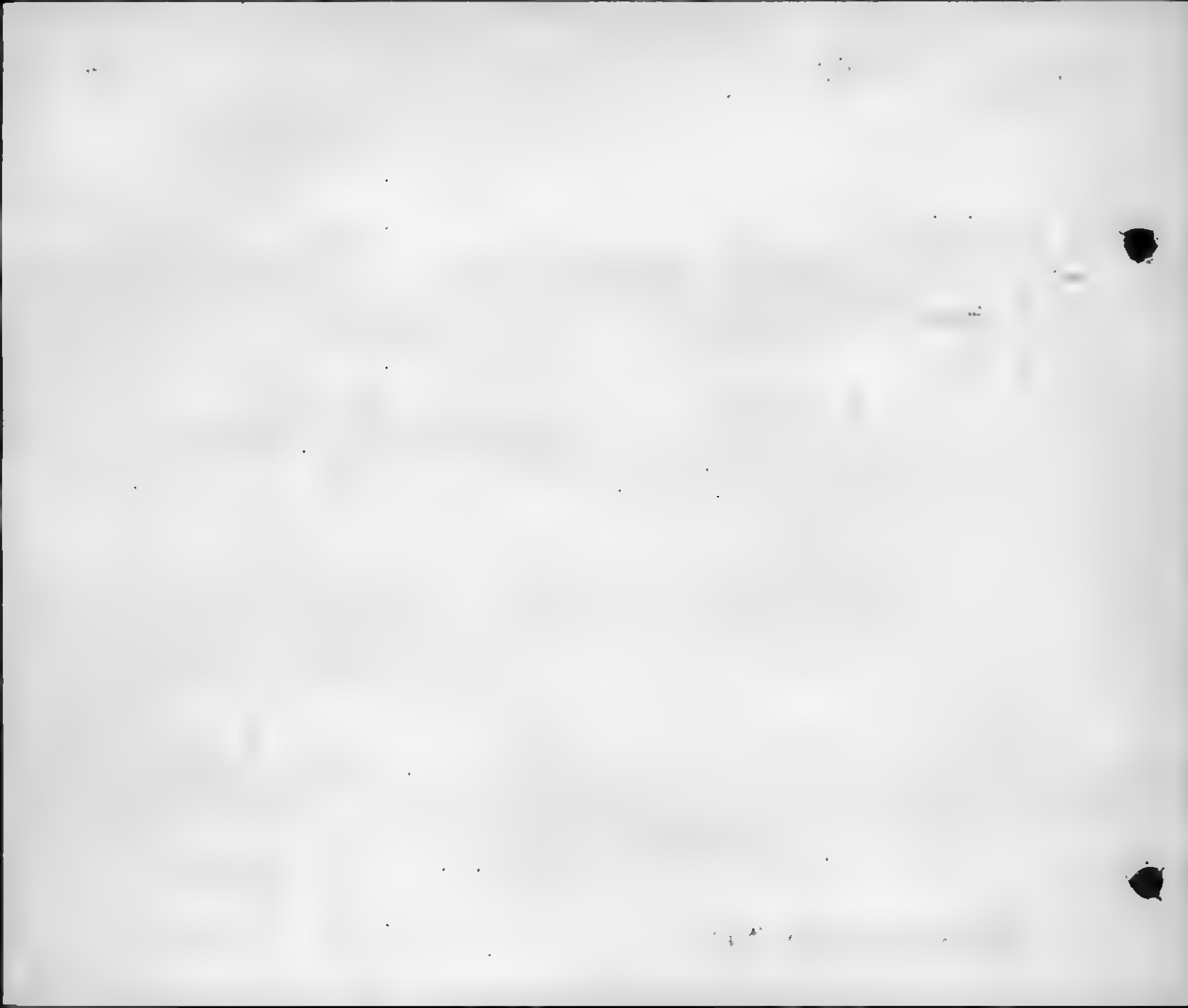


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VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11669 CERTIFICATE OF DEATH 11655

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB 42 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. STATE Virginia		f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stafford	
g. STREET ADDRESS Highway #1		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		i. DATE OF DEATH October 10 1961	
j. SEX Male		k. COLOR OR RACE Caucasian		l. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
m. AGE (in years last birthday) 12 yrs.		n. DATE OF BIRTH 11-22-48		o. IF UNDER 1 YEAR Months Days Hours Min.	
p. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		q. KIND OF BUSINESS OR INDUSTRY		r. BIRTHPLACE (County & State or foreign country) Virginia	
s. CITIZEN OF WHAT COUNTRY? USA		t. FATHER'S NAME Andrew Frank Satkofsky		u. MOTHER'S MAIDEN NAME Betty StClair	
v. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give year or dates of service] No		w. SOCIAL SECURITY NO.		x. INFORMANT Andrew Frank Satkofsky, Same as #2 above	
y. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ewings Sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>7-11-X</u> (a), stating the underlying cause last. DUE TO (c)		z. INTERVAL BETWEEN ONSET AND DEATH		aa. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ab. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		ac. I certify that (1) (this hospital) attended the deceased from Aug. 29, 1961 to Oct. 10, 1961 that (2) (we) last saw the deceased alive on Oct. 10, 1961, and that death occurred at 5:50 AM from the causes and on the date stated above.		ad. SIGNATURE J. A. G. DE WAAL M.D. 22b. DATE SIGNED Oct 10, 1961	
ae. PHYSICIAN'S NAME (Type) J. A. G. DE WAAL, M.D.		af. ADDRESS U. S. Naval Hospital, Bethesda, Md.		ag. REC'D BY REGISTRAR DATE OCT 16 '61	
ah. BURIAL, CREMATION, REMOVAL (Specify) Burial		ai. DATE THEREOF 13 Oct 1961		aj. NAME OF CEMETERY OR CREMATORY Arlington National	
ak. LOCATION (City, town or county) Arlington		al. (State) Va.		am. REGISTRAR'S SIGNATURE C. L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

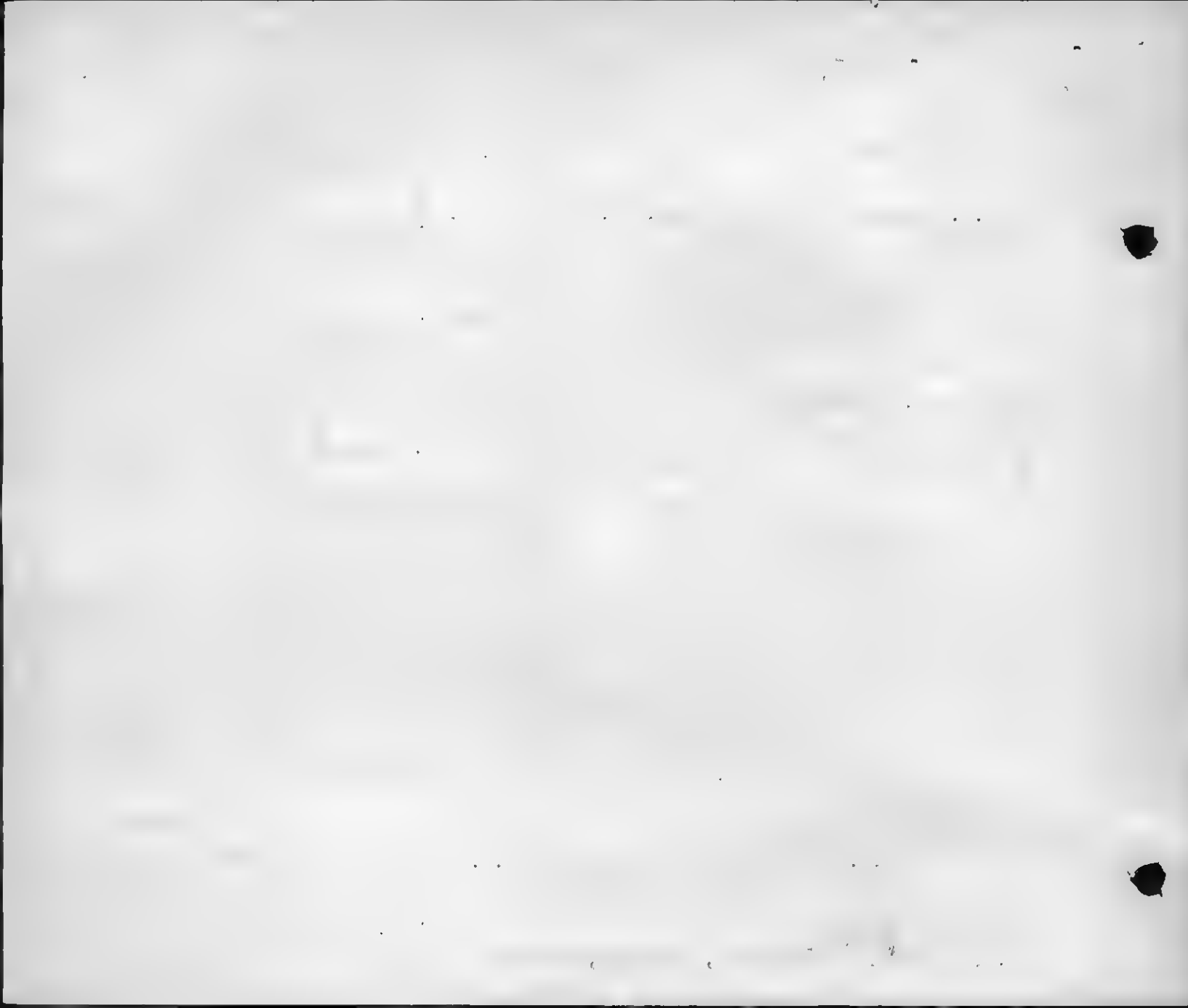
CERTIFICATE OF DEATH

11670

11656

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Florida			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS Wtrs. R8			
3. NAME OF DECEASED (Type or print) Joy Webb SAUNDERS				4. DATE OF DEATH Oct. 27 1961			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 8-2-61		9. AGE (In years last birthday) yrs. 2 Months 23 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Key West, Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter E. SAUNDERS				14. MOTHER'S MAIDEN NAME Dorothy COOPER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 17. INFORMANT (F) Walter E. SAUNDERS (same as #2 above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 m 25d			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? monoglycerin YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 25 Oct., 1961, to 10-27-....., 1961 that (I) (we) last saw the deceased alive on 27 Oct., 1961, and that death occurred at 1125 PM the causes and on the date stated above.							
22a. SIGNATURE Howard A. Pearson M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-28-61	
22c. PHYSICIAN'S NAME (Type) H.A. PEARSON LCDR MC USN				22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-31-61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE R.S. PUMPHREY				ADDRESS R.S. PUMPHREY FUNERAL HOME, BETHESDA, MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11657

FOR STATE
HEALTH DEPT.

(M)

0471

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium Hospital

3. NAME OF DECEASED

(Type or print)

Albert

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

November 9, 1899

9. AGE (In years last birthday)

61 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

4. DATE OF DEATH

October 8, 1961

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Johnstown, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY/Carl SCHNEIDER

14. MOTHER'S MAIDEN NAME

Frieda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Wife (Spouse)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Bluschant

M.D.

EXAMINER'S NAME (Type)

FRANK J. BLUSCHANT

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

10-8-61

22a. BURIAL, CREMATION REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

10/11/1961

22c. NAME OF CEMETERY OR CREMATORY

RICHLAND CEMETERY

22d. LOCATION (City, town, or country) (State)

RICHLAND TOWNSHIP, PENNA.

23. FUNERAL DIRECTOR

Joseph G. Gindler

ADDRESS

1756 PA. AVE., N.W., D.C. 6

24a. REC'D BY REGISTRAR

OCT 10 '61

24b. REGISTRAR'S SIGNATURE

Arthur E. Kraus



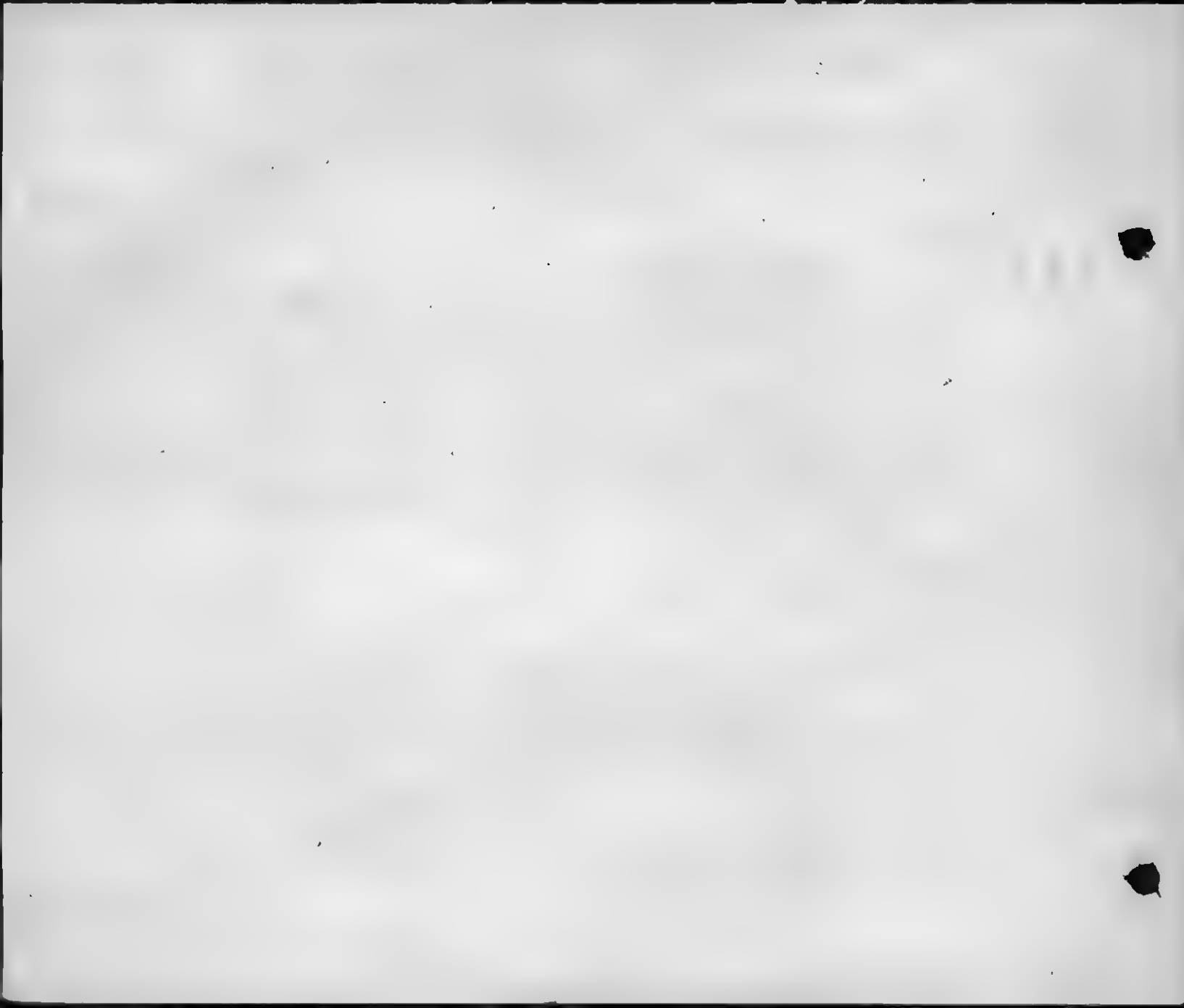
delay is necessary,
general director. Page
ed for your files.
te Board of Health,
n. (

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director; give Page 4 to the State Medical Examiner's Office along with form PM-3. Page 5 may be retained by you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Medical Examiner's Office. If the body is to be buried or cremated, return page 4 to the State Medical Examiner's Office. If the body is to be interred in a vault, return page 4 to the funeral home. Return page 5 to the State Medical Examiner's Office if the body is to be buried or cremated, and in any event within 2 hours after death, or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

VS. AISME
5M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 15 DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp		d. STREET ADDRESS 957 East West Hwy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard (NWN) Schuman		4. DATE OF DEATH 10 18 1961		5. SEX M	
6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-99 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROGGER		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Sam Schuman		14. MOTHER'S MAIDEN NAME Sarah - ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 097-05-1612		17. INFORMANT Mrs. Alice Schuman - wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschank		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-18-61	
EXAMINER'S NAME (Type) FRANK J. BROSHANK		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-19-61		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	
22d. LOCATION (City, town, or country) FALLS CHURCH, VA		22e. REC'D BY REGISTRAR DATE OCT 20 '61		22f. REGISTRAR'S SIGNATURE Wm. L. K...	
23. FUNERAL DIRECTOR BERNARD DANZANSKY + SONS - 3501-14 1st NW					



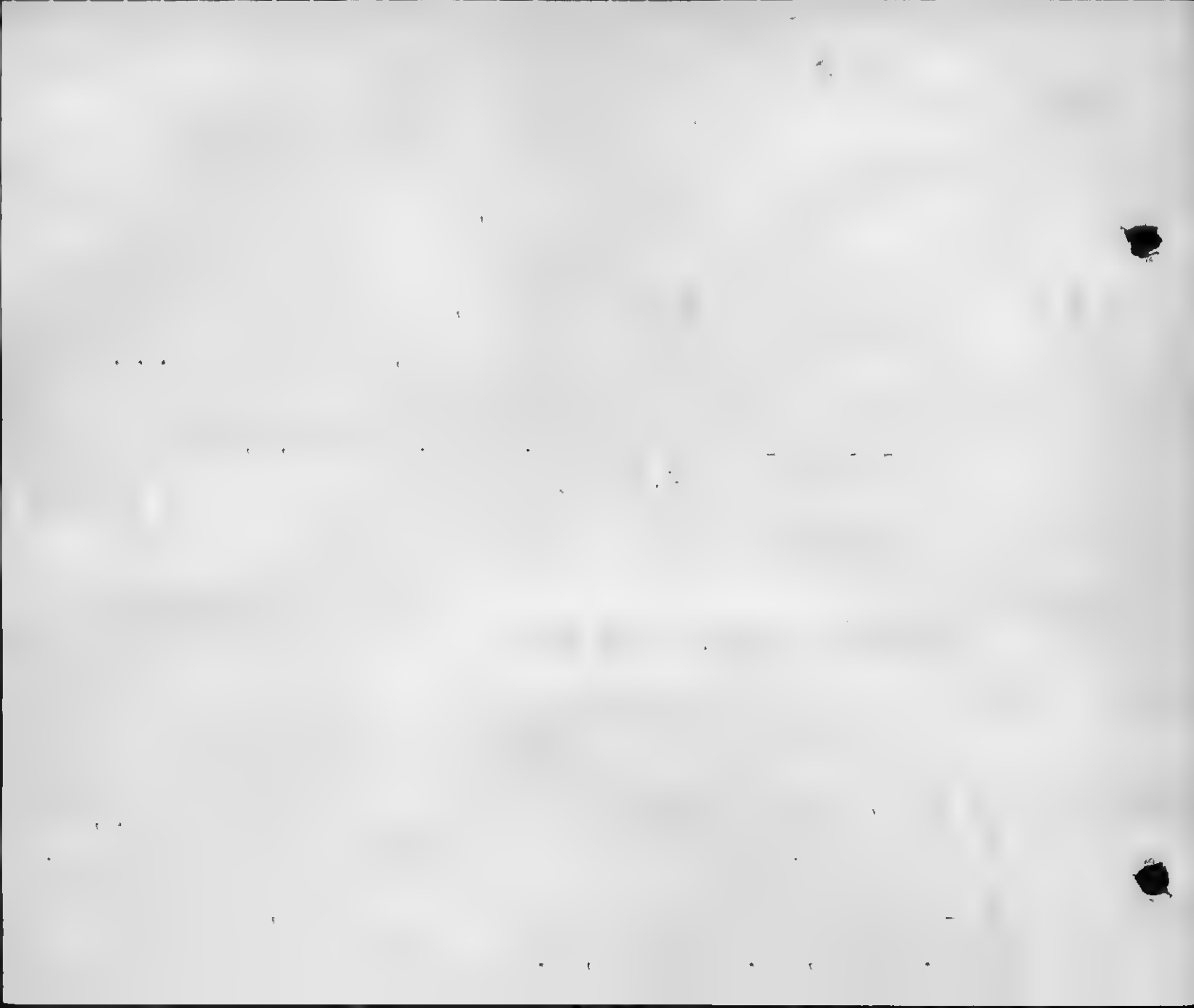
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11673

11653

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON GARDENS NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,300 BROOKMOOR DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIA WILHEMINA		4. DATE OF DEATH OCTOBER 8		9. AGE (In years, last birthday) 92 yrs. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH APRIL 11, 1869	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (retired)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State or foreign country) Brooklyn, New York	
13. FATHER'S NAME Klaus Wiesen		14. MOTHER'S MAIDEN NAME Julia Behlem		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MRS. FRANK W. SCHWEDHELM, 10,300 BROOKMOOR DRIVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 493X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (b) 493X DUE TO Hypertension, Cardiac weakness (c) 493X DUE TO Hypertension, Cardiac weakness		19. INTERVAL BETWEEN ONSET AND DEATH 1 week		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1959 to Oct 8 , 1961, that (I) (we) last saw the deceased alive on Oct 8 , 1961, and that death occurred at Oct 8 , 1961, from the causes and on the date stated above.					
22a. SIGNATURE John N. Andrews		22b. DATE SIGNED Oct 9, 1961		22c. PHYSICIAN'S NAME (Type) JOHN N. ANDREWS	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 10/11/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	
23d. LOCATION (City, town or county) Brooklyn, New York		23e. REC'D BY REGISTRAR OCT 11 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Hines	
24. FUNERAL DIRECTOR'S SIGNATURE Varney E. Pumphrey, Inc.		24a. ADDRESS 34 Georgia Avenue		24b. CITY Silver Spring, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

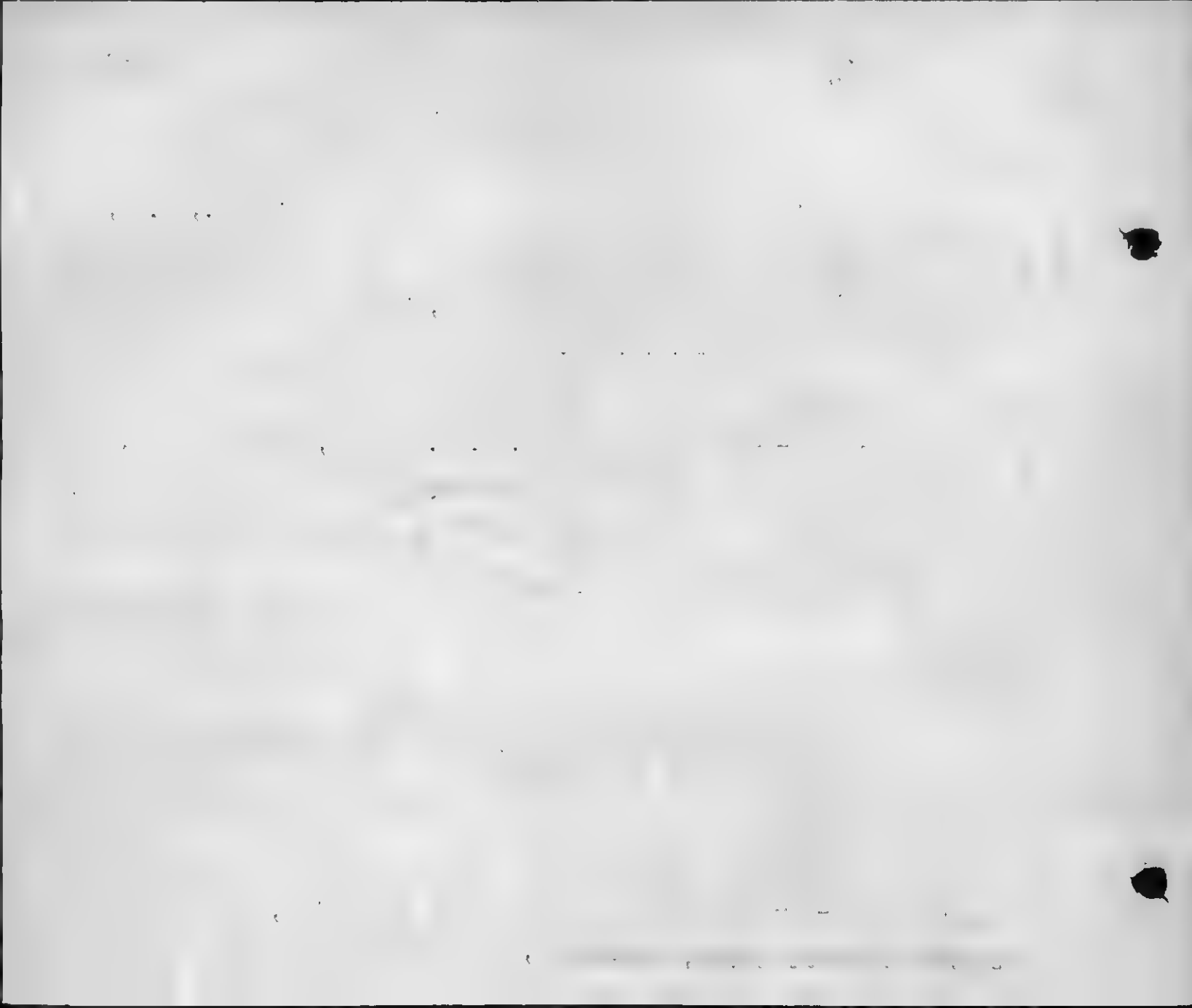
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11674

11660

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reesor Sanitarium & Hospital				d. STREET ADDRESS 3337 Reservoir Rd., N.			
3. NAME OF DECEASED (Type or print) First Middle Last ALICE KENNEDY SHALLBERG				4. DATE OF DEATH Month Day Year October 13 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Phillip Kennedy				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. W. H. Quealy, 1625 35th St, NW				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular disease DUE TO Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 week				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 12 1961 to Oct 12 1961 , that (I) (we) last saw the deceased alive on Oct 12 1961 , and that death occurred at 10:00 M, from the causes and on the date stated above.							
22a. SIGNATURE J. A. Gannon Jr.				22b. DATE SIGNED Oct 12 1961			
22c. PHYSICIAN'S NAME (Type) JAMES A. GANNON JR.				22d. ADDRESS 5141-34th St NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-1961		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION (City, town or county) (State) Moline, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Sewer's Sons				ADDRESS Washington, DC		25a. REC'D BY REGISTRAR OCT 16 '61	
				25b. REGISTRAR'S SIGNATURE Charles L. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

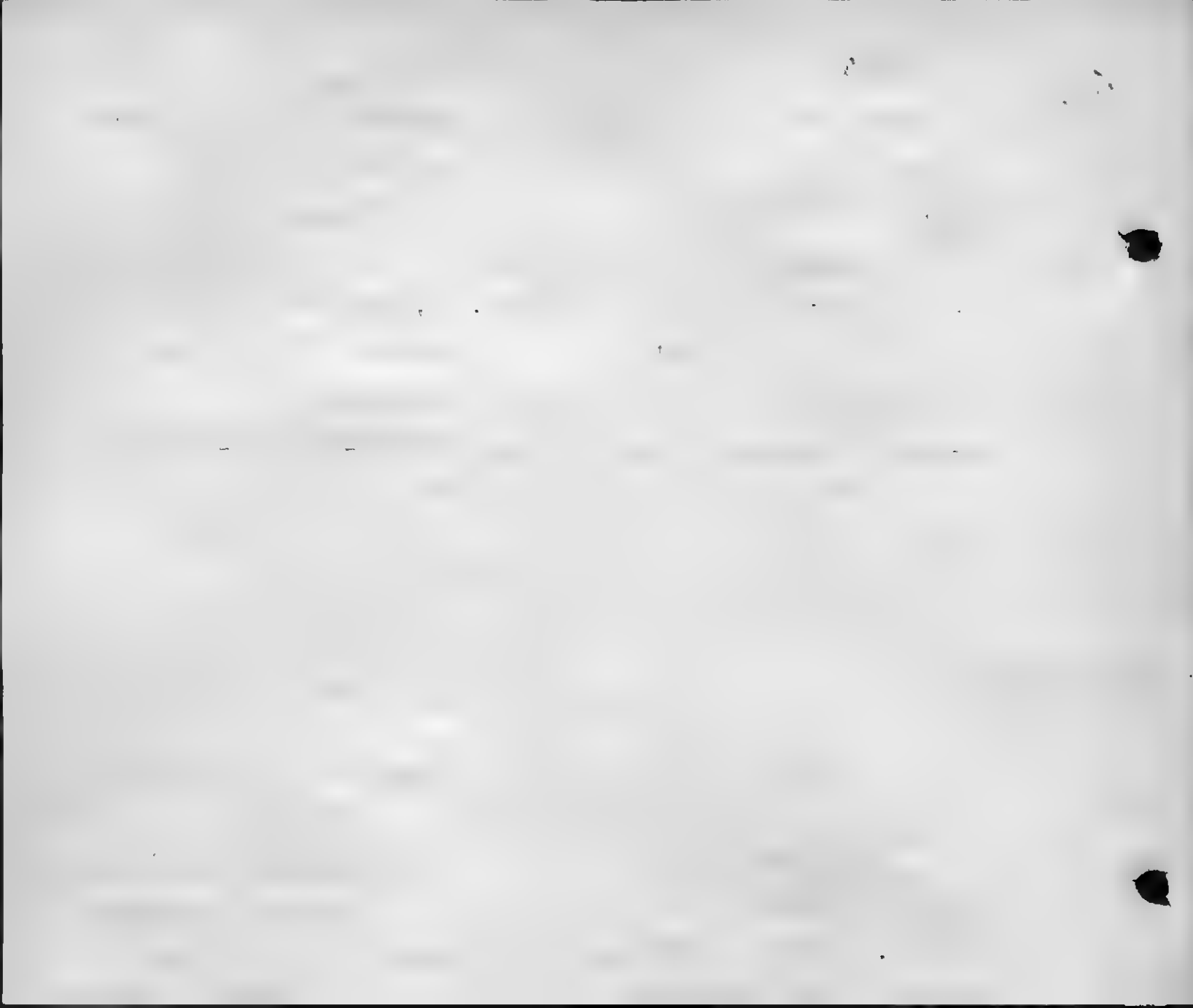
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11675

11661

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. Marilea Nursing Home 14511 Colesville Road d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rockville 301 Baltimore Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 301 Baltimore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roger 4. DATE OF DEATH October 2 1961 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 17, 1876 9. AGE (in years last birthday) 85 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Shaw 14. MOTHER'S MAIDEN NAME Artie Garrett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. Catherine Bride-Daughter-same 2d 17. INFORMANT 2d		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Trophic ulcer of leg	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1, 1960 to 10/2/61 , that (I) (we) last saw the deceased alive on 10/1/61 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones 22b. DATE SIGNED 10/2/61 22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES 22d. ADDRESS 809 Viers Mill Rd. Rockville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/4/61 23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery 23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland 25a. REC'D BY REGISTRAR OCT 4 '61 25b. REGISTRAR'S SIGNATURE Arthur L. House			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11676

11662

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
c. LENGTH OF STAY IN b 168 days		d. STREET ADDRESS 6110 54th Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maude Violet Sibert		4. DATE OF DEATH October 3 1961		
5. SEX Female		6. COLOR OR RACE Caucasian		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 23, 1885		
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours M'n.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Albert Barton		14. MOTHER'S MAIDEN NAME Nancy Fisher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199 Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (b) Anaplastic Carcinoma DUE TO cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (A) (this hospital) attended the deceased from April 19, 1961, to October 3, 1961, that (B) (we) last saw the deceased alive on October 3, 1961, and that death occurred at 4:20 PM from the causes and on the date stated above.				
22a. SIGNATURE William F. Warrender M.D.		22b. DATE SIGNED October 4, 1961		
22c. PHYSICIAN'S NAME (Type) WILLIAM F. WARRENDER, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 6, 1961		
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS, Riverdale, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 '61		
25b. REGISTRAR'S SIGNATURE Arthur S. Kline				



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1677</div> <div>1663</div> </div> <div> <div>1677</div> <div>1663</div> </div> </div> <div> <div> <div>1677</div> <div>1663</div> </div> <div> <div>1677</div> <div>1663</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN YEARS Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 310 Lincoln Ave						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 310 Lincoln Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emily Marie Sikorra First Middle Last 4. DATE OF DEATH Oct 6 1961 Month Day Year						5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5/9/1889 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 72 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Minn. 12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Chris Behnken 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Emily Hida (daughter) Address Item 2						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 DUE TO (b) 420.1 DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous coronary disease 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/7/61 Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Oct. 9, 1961 22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery 22d. LOCATION (City, town, or country) (State) Prince Geo. Co. Maryland											
23. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St NW DC. 24a. REC'D BY REGISTRAR OCT 10 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hines											

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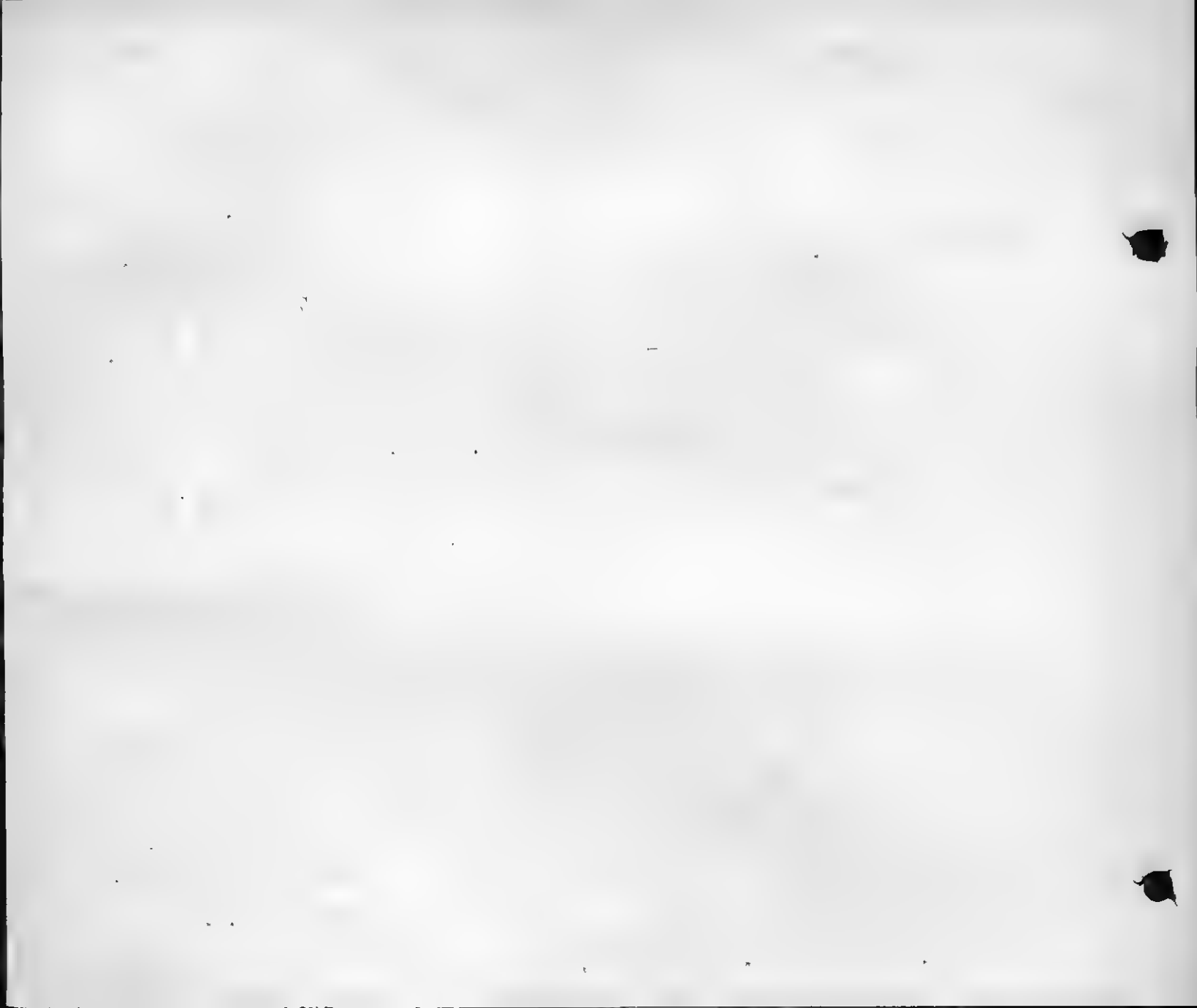
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11678

11664

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
				d. STREET ADDRESS 7301 Piney Branch Rd.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle Bond Last Smith				4. DATE OF DEATH Month October Day 20 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/90	
				9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney				10b. KIND OF BUSINESS OR INDUSTRY Self-employed			
13. FATHER'S NAME Benjamin F. Smith				14. MOTHER'S MAIDEN NAME Emma Bond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-38-3675		17. INFORMANT Wife. Same as above	
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL Hemorrhage 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LEFT Frontoparietal Brain Tumor ? DUE TO (c) 24h INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1955 to Oct 20 1961 , that (I) (we) last saw the deceased alive on Oct 19 1961 , and that death occurred at 8 AM , from the causes and on the date stated above.							
22a. SIGNATURE Merrill M. Cross				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/61	
22c. PHYSICIAN'S NAME (Type) MERRILL M. C. CROSS				22d. ADDRESS 8248 Georgia ave Silver Spring Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DATE OCT 24 '61	
				25b. REGISTRAR'S SIGNATURE 1 A J. J. J.			

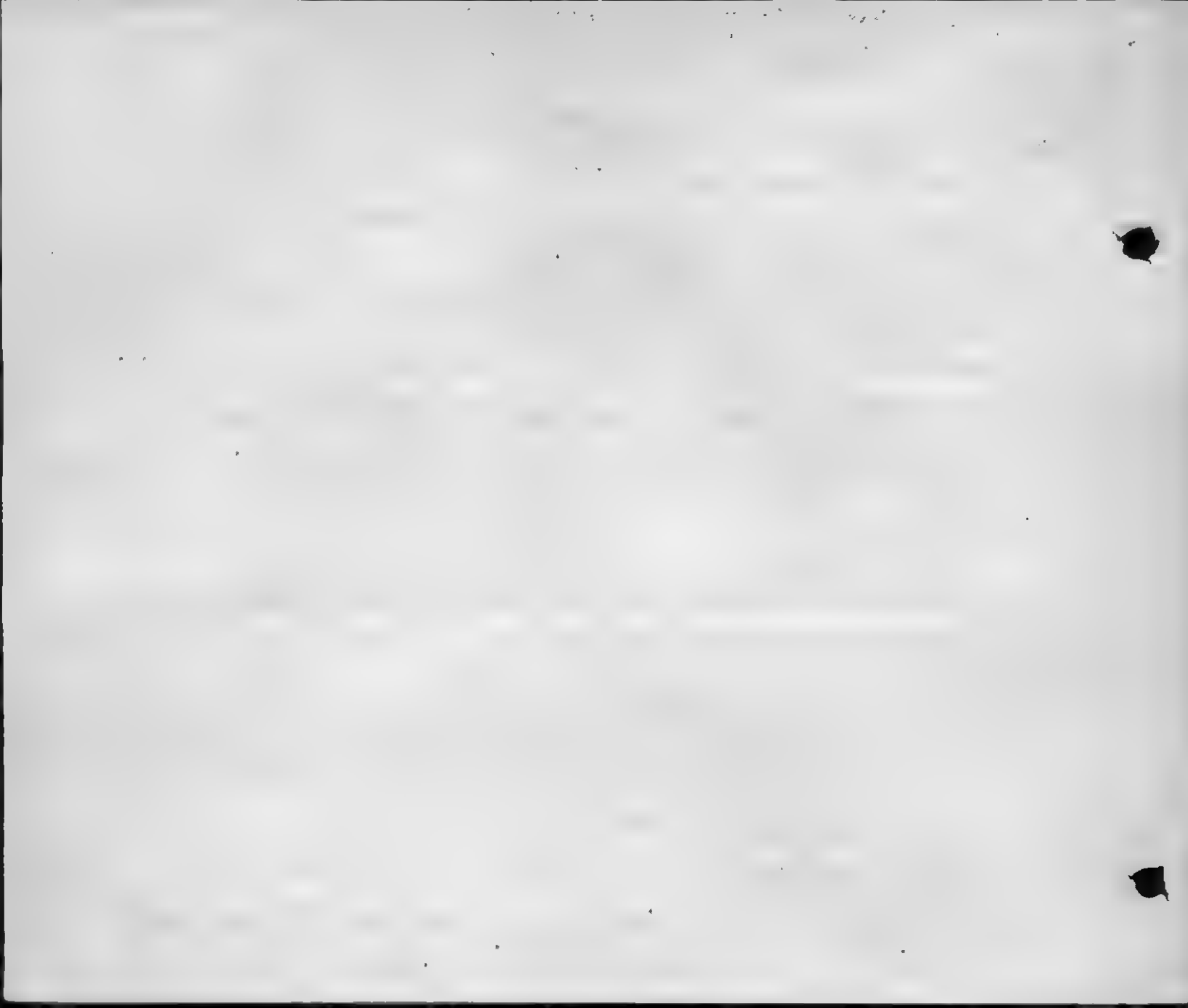


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11679 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11665

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY in lb D.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 13917 BAUER DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle REED Last SMITH		4. DATE OF DEATH Month OCT. Day 8 Year 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1888 9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME Daniel Hogue		14. MOTHER'S MAIDEN NAME Chaseldine, Clara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Son-in Law		Address Same as above.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420/ DUE TO Conditions, if any, which gave rise to immediate cause (b) 420/ (a), stating the underlying cause last. DUE TO (c) 420/			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). History of previous coronary disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brochart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-9-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/11/61	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR The S.H. Hines Company		24. REC'D BY REGISTRAR OCT 11 '61	
25. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11666

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be extended by the State Board of Health. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4315 Chestnut st</u>		d. STREET ADDRESS <u>4315 Chestnut st</u>	
3. NAME OF DECEASED (Type or print) <u>Chetcheu</u> <u>Spaulding</u>		4. DATE OF DEATH <u>Oct</u> <u>3</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-40</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>	
13. FATHER'S NAME <u>Harriet V. Graves</u>		14. MOTHER'S MAIDEN NAME <u>Gillette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>John H. Spaulding - Sister</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> 195.3 Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Was found collapsed in living room of her home 10-3-61</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-3-61</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William A. Pumphrey</u>			



96



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

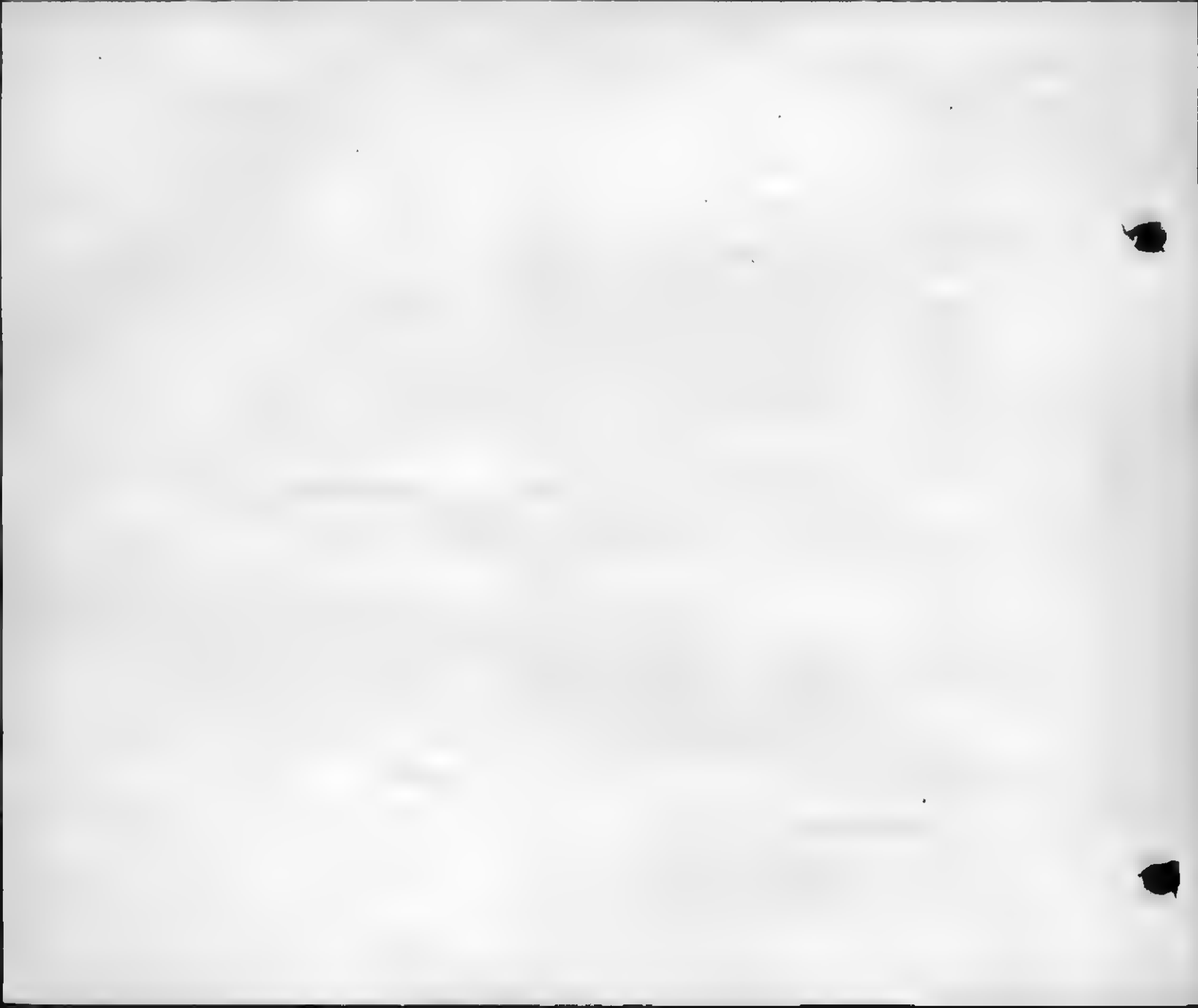
CERTIFICATE OF DEATH

Reg. Dist. No.

11667

11681

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10620 GEORGIA AVENUE		d. STREET ADDRESS 13310 LYDIA ST	
3. NAME OF DECEASED (Type or print) First EMMA Middle - Last SPECTOR		4. DATE OF DEATH Month 10 Day 22 Year 1961	
5. SEX FEMALE	6. COLOR OF RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MOSES WEISER		14. MOTHER'S MAIDEN NAME ESTHER KOSVEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MOZART ISPECTOR		Address 13412 DAUPHINE ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion myocardial infarction 420.1 DUE TO (b) coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 10/22/61 3:20 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15/58 to 10/22/61 , that I last saw the deceased alive on 10/22/61 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald Nelson		ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spring, Md.	
DATE SIGNED 9/26/61			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/24/61	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEM.		22d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg		ADDRESS 4217-9220 M	
24a. REC'D BY REGISTRAR OCT 25 61		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11682

11668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4801 Conn. Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Mae Stanton</u> First Middle Last		4. DATE OF DEATH <u>Oct. 14 1961</u> Month Day Year	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/28/84</u> Year Month Day	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. of Co.</u>		9. AGE (In years, last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
13. FATHER'S NAME <u>Walter Morrison</u>		14. MOTHER'S MARRIAGE NAME <u>Alvin L. Aubine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give order or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Alvin L. Aubine</u> Address <u>1500 Overhill Rd. Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum</u> Conditions, if any, which gave rise to immediate cause (b) <u>ISB.D</u> (a), stating the underlying cause last (c) <u>DUE TO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. <u>8:10</u> p.m. <u>10-14-1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that () (this hospital) attended the deceased from... <u>January 1959</u> to <u>October 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 14, 1961</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Michael J. McInerney M.D.</u> 22c. PHYSICIAN'S NAME (Type) _____		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1150 - CONN Avenue, D.C.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>BURIAL</u> <u>10-17-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u> ADDRESS <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin's Sons, 1756 Pa. Ave. NW</u>		25a. REC'D BY REGISTRAR <u>OCT 17 '61</u> DATE _____	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		23d. LOCATION (City, town or county) <u>WASHINGTON, DC</u> (State) _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11670

1
FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.O.A. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1213 East Chase Street</u>		
3. NAME OF DECEASED (Type or print) <u>Archie</u> First Middle Last			4. DATE OF DEATH <u>Oct. 23 1961</u> Month Day Year		
5. SEX <u>Male</u> <u>Negro</u>			6. COLOR OR RACE <u>Negro</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>2-12-19</u>		
9. AGE (In years last birthday) <u>42</u> yrs.			10. IF UNDER 1 YEAR Months _____ Days _____		
11. IF UNDER 24 HRS. Hours _____ Min. _____			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ligon & Ligon</u>		
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Caesar Stuckey</u>			14. MOTHER'S MAIDEN NAME <u>Bella Bentler</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes World War 2 1941-42-11/4</u>			16. SOCIAL SECURITY NO. <u>2249-42-114</u>		
17. INFORMANT <u>Same</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> (b) <u>Coronary Arteriosclerosis</u> (c) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) _____			20g. (County) _____		
20h. (State) _____			21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>10-24-61</u>		
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			NAME (Type) <u>FRANK J. Broschert</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			22b. DATE THEREOF <u>10-26-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>M.E. ENCKSON - 1129 N. CAROLINE ST.</u>			22d. LOCATION (City, town, or country) <u>FLORENCE, S.C.</u>		
23. FUNERAL DIRECTOR <u>M.E. ENCKSON - 1129 N. CAROLINE ST.</u>			24a. REC'D BY REGISTRAR <u>OCT 26 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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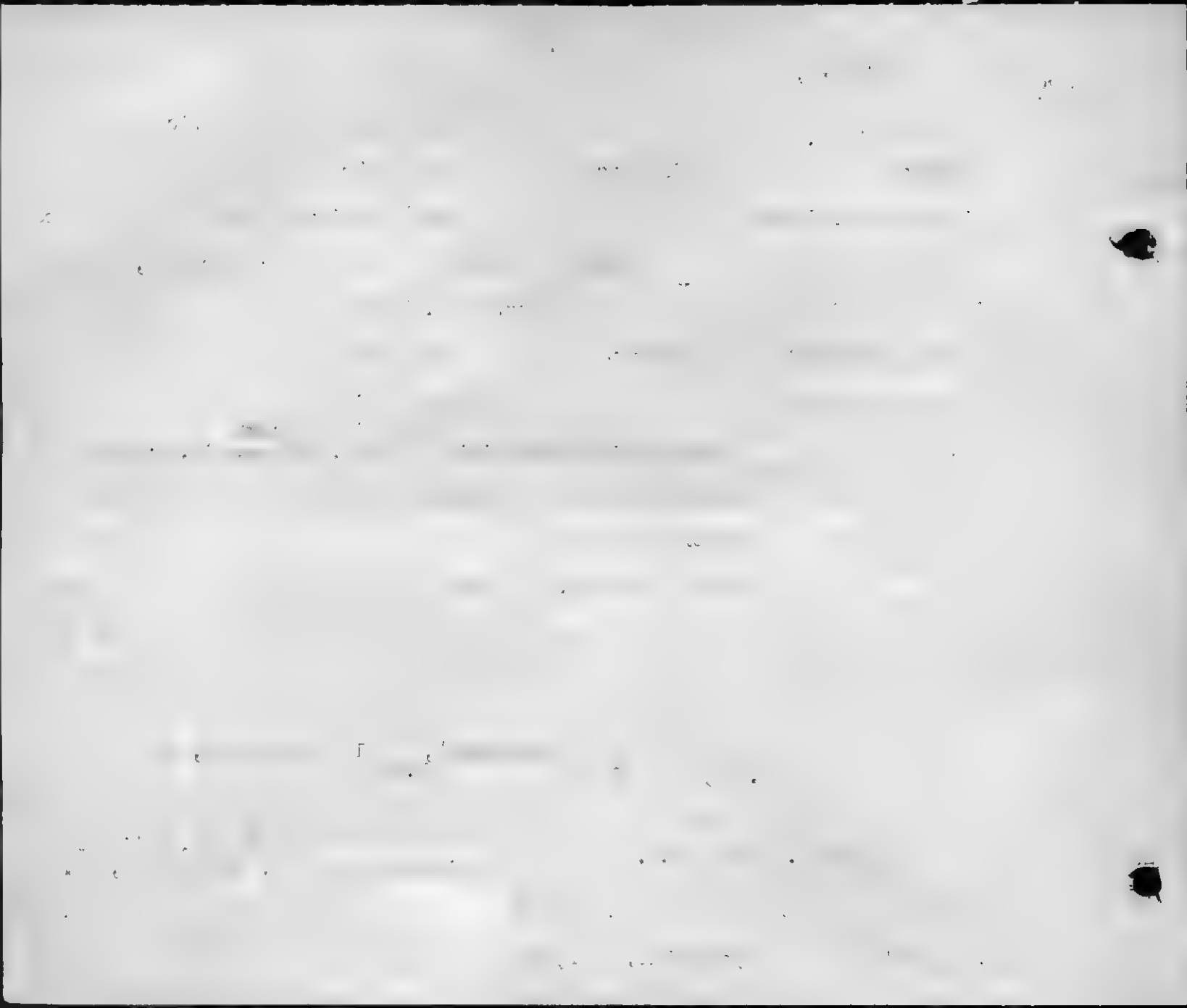
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11684
11671
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 16 Days		2. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		d. STREET ADDRESS 5014 Sheridan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD WARREN STUNKLE		First		Middle		Last		4. DATE OF DEATH October 20, 1961		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE County & State or foreign country Maryland		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Lindsey Stunkle		14. MOTHER'S MAIDEN NAME Margaret Lilly		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia with a gram negative organism 204.3 DUE TO (b) Hepatic Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Acute Myelogenous leukemia												INTERVAL BETWEEN ONSET AND DEATH 1 Day 2 Days 2 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) October 4, 1961 to October 20, 1961		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from October 4, 1961 to October 20, 1961 , that (I) (we) last saw the deceased alive on Oct. 20, 1961 , and that death occurred on October 20, 1961 from the causes and on the date stated above.															
22a. SIGNATURE Carl J. Bentzel		22b. DATE SIGNED 10-21-61		22c. PHYSICIAN'S NAME (Type) Carl J. Bentzel M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) Colmar Manor, Md.		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR OCT 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

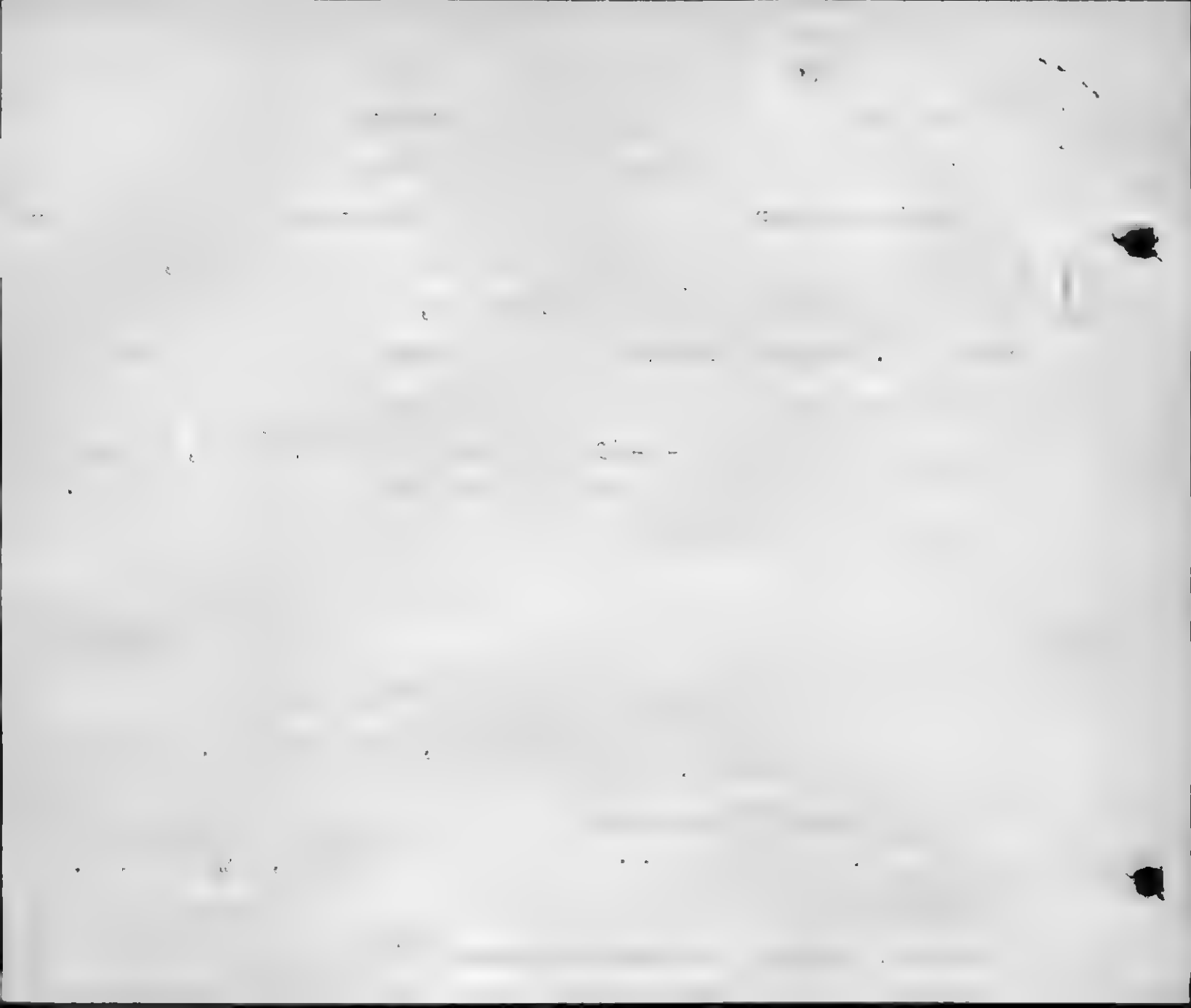
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11685

11672

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 40 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California b. COUNTY San Francisco c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) San Francisco d. STREET ADDRESS 2150 33rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE HELEN SULLIVAN First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH November 9, 1905 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH October 9, 1961 Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Co. Executive 10b. KIND OF BUSINESS OR INDUSTRY Insurance 11. BIRTHPLACE County & State, or (overseas country) California 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Joseph Pyne 14. MOTHER'S MAIDEN NAME Mary Murphy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 17. INFORMANT The Medical Record Address 558-09-1430 The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adrenal cortical tumor DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4 Days		INTERVAL BETWEEN ONSET AND DEATH 6 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 Days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 30, 1961 to October 9, 1961 that (I) (we) last saw the deceased alive on October 9, 1961 and that death occurred at 7:30AM from the causes and on the date stated above.			
22a. SIGNATURE J. David Heywood M.D.		22b. DATE SIGNED 10-9-61	
22c. PHYSICIAN'S NAME (Type) J. David Heywood M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/10/61		23b. DATE THEREOF 10/10/61	
23c. NAME OF CEMETERY OR CREMATORY Golden Gate Cemetery		23d. LOCATION (City, town or county) (State) San Bruno, California	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 13 '61 25b. REGISTRAR'S SIGNATURE James S. Kraus	



11686

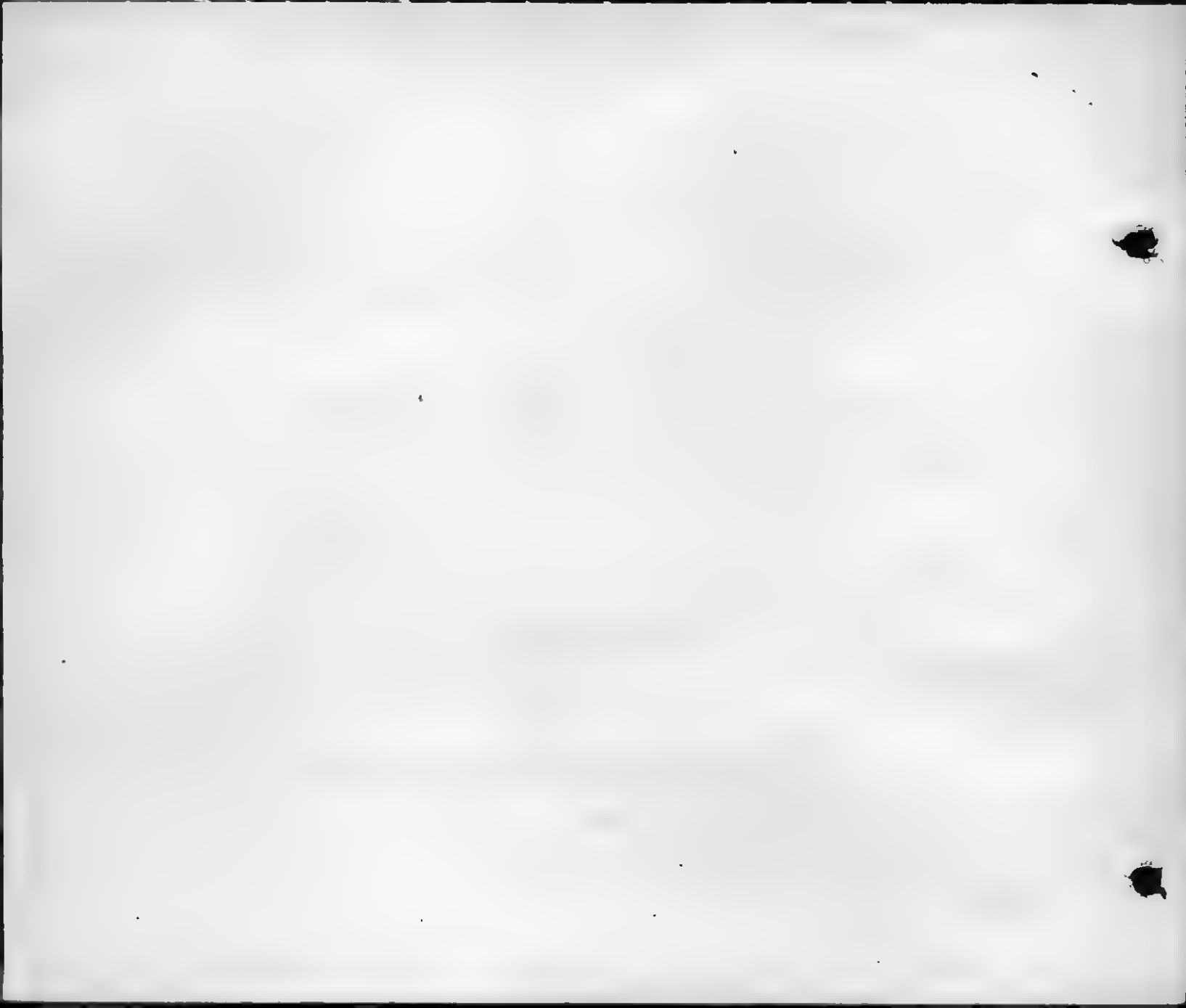
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village</u>			c. LENGTH OF STAY IN 1b <u>21 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Village.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5510 Grove St.</u>				d. STREET ADDRESS <u>5510 Grove St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>L.</u> Last <u>Swink</u>				4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 18, 1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>Robert L. Swink</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Webster.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Anna Swink (wife), 5510 Grove St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u></p> <p><u>IX</u> DUE TO (b) <u>Cerebral Arteriosclerosis.</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis.</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 months.</u></p> <p><u>3 1/2 months.</u></p> <p><u>20 years.</u></p> </div> </div>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1961</u> to <u>Oct. 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Humphreys Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys Jr.</u>				22d. ADDRESS <u>917 20th St. N.W. Washington D.C.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>Oct 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

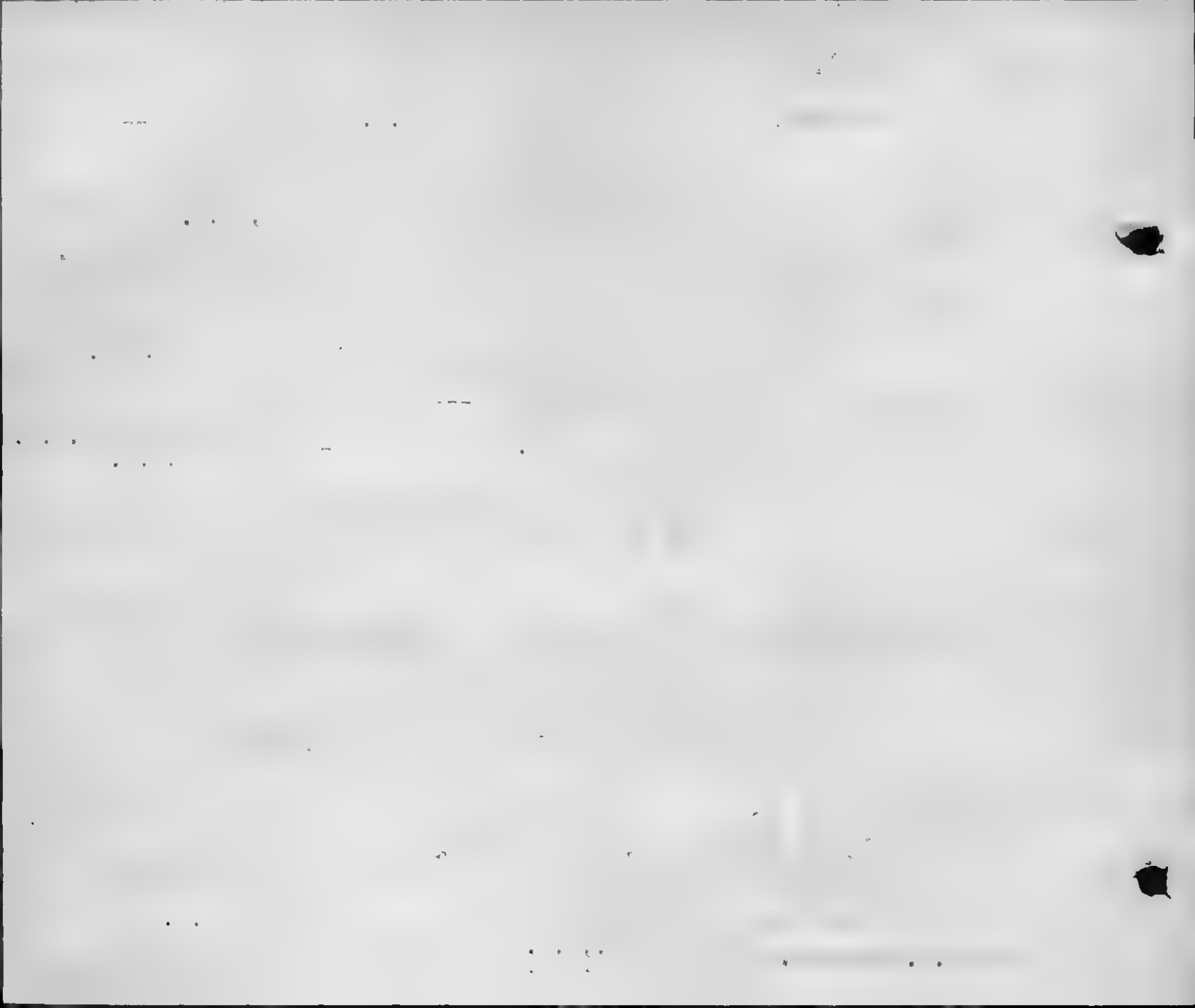
11687

CERTIFICATE OF DEATH

11674

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE D.C. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bel Pre Nursing & Convalescent Home		e. STREET ADDRESS 2220 20th Street, N.W.	
3. NAME OF DECEASED (Type or print) GERTRUDE NICKELL		4. DATE OF DEATH Month Oct Day 28 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME --- Nickell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Address Mrs. Manning Dyer-5033 Loughboro Rd. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic Heart Disease & Congestive Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 27 , 19 61 , to Oct 28 , 19 61 , that (I) (we) last saw the deceased alive on Oct 28 , 19 61 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Neil P. Campbell		22b. DATE SIGNED 10/26/61	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS Kenesaw Apt	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/31/61	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25. REC'D BY REGISTRAR NOV 1 '61	
25a. ADDRESS 2901 14th St., N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11675

11688

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 657, Silver Spring				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LE DEAU GARDENS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle MAE Last THOMPSON				4. DATE OF DEATH Month Oct. Day 28 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27-1876	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James Page				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital records, Nursing Home				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, Cardiac Asthma DUE TO (c) Arterio sclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1959 , 19____, to Oct 27 , 19 61 , that I last saw the deceased alive on Oct 27 , 19 61 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St., Kensington, Maryland DATE SIGNED 10/28/61							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.							
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.				Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/61		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Clarksburg, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Feltner				ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE NOV 1 '61	
				24b. REGISTRAR'S SIGNATURE Chas L. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

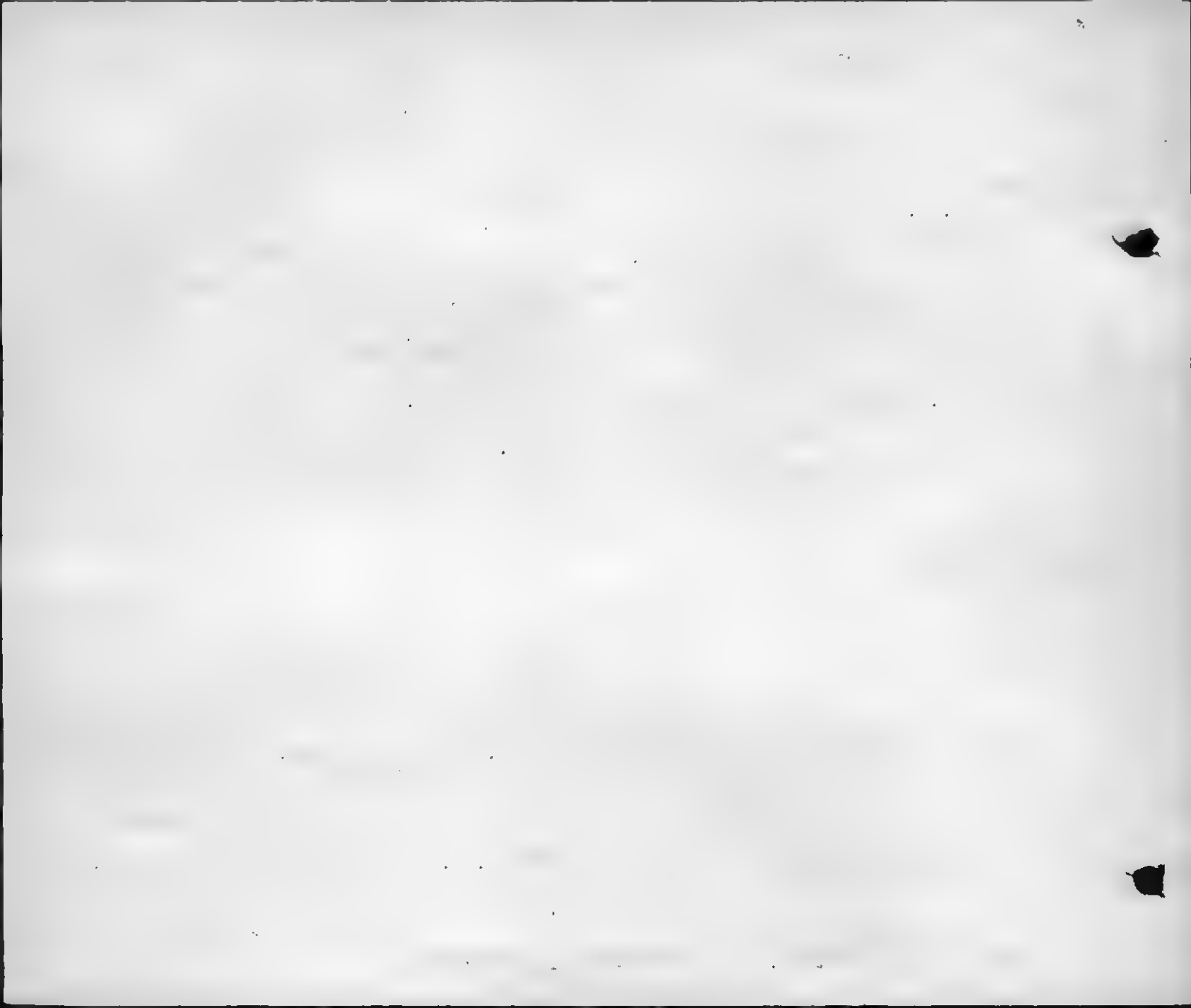
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11689

CERTIFICATE OF DEATH

11676

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
f. STREET ADDRESS 3918 Wilson Blvd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Eugene Thompson		4. DATE OF DEATH October 2 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1961	
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Bethesda, Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack E. Thompson		14. MOTHER'S MAIDEN NAME Janice C. Bice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Jack E. Thompson, Same as #2 above	
17. INFORMANT Jack E. Thompson, Same as #2 above		Address Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & Respiratory Arrest DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 30, 1961 , to Oct. 2, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 2, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frederic Schulaner M.D.			
22b. DATE SIGNED 2 Oct 1961			
22c. PHYSICIAN'S NAME (Type) FREDERIC SCHULANER, LT MC USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE THEREOF 3 Oct 1961			
23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Memorial Gardens Morgantown W.Va.			
23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert M. Humphrey			
25a. REC'D BY REGISTRAR OCT 4 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

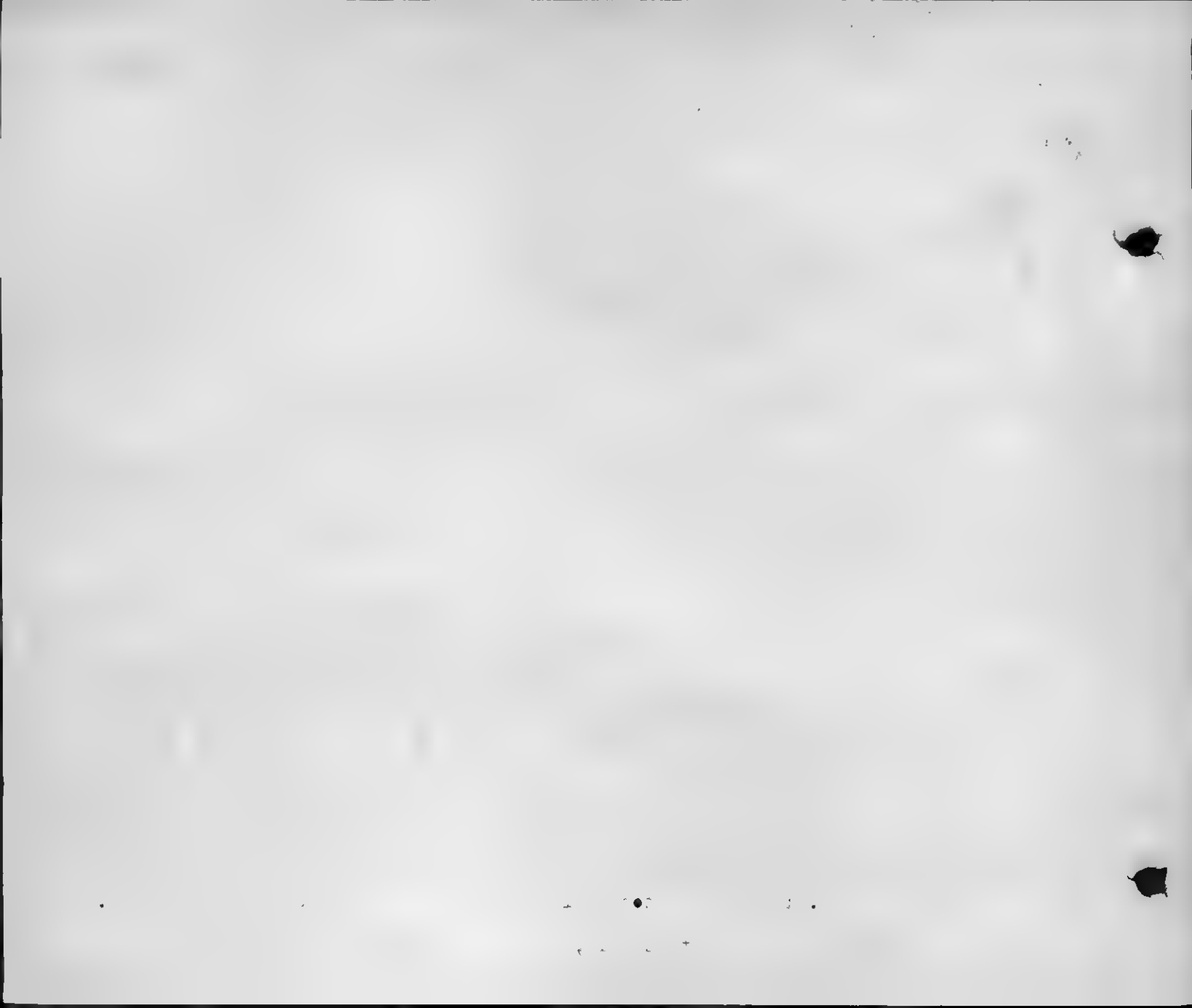
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1230-1

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harris Farm - Falls Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if not in on. Residence before admission) e. STATE <u>Ind</u> f. COUNTY <u>Montg</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> h. STREET ADDRESS <u>Harris Farm - Falls Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Lynn Trent</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 - 1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
13. FATHER'S NAME <u>Samuel Trent</u>		14. MOTHER'S MAIDEN NAME <u>Betty Knight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO <u>Betty Trent (mother)</u>	
17. INFORMANT <u>Elmer</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>2</u> <u>hours</u> <u>dead in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 1 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCAT ON (City, town, or country) (State) <u>Laytonsville Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 8 '61</u>	
ADDRESS <u>Laytonsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
11691																			
1967																			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. #2 Gaithersburg d. STREET ADDRESS 1														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					c. LENGTH OF STAY IN IL 12					d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital									
3. NAME OF DECEASED (Type or print) JOHN THOMAS TRIGGER					4. DATE OF DEATH 10 - 3 19 61					5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX Male					6. COLOR OR RACE white					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH 9-6-85					9. AGE (In years last birthday) 76 yrs.					10. IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitor					10b. KIND OF BUSINESS OR INDUSTRY unknown					11. BIRTHPLACE (County & State, or foreign country) Maryland									
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME John Trigger					14. MOTHER'S MAIDEN NAME Belle Trigger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown					16. SOCIAL SECURITY NO. 214-18-8604					INFORMANT hospital records									
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac Decompensation Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Terminal Pneumonia DUE TO DUE TO					18. INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from January, 1961 to 10-3 , 1961, that (I) (we) last saw the deceased alive on 10-3 , 1961, and that death occurred at 10-3 M, from the causes and on the date stated above.										22a. SIGNATURE L. I. Leal					22b. DATE SIGNED 10-3-61				
22c. PHYSICIAN'S NAME (Type) L. I. Leal, M.D.					22d. ADDRESS Gaithersburg, Md.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 10-6-61					23c. NAME OF CEMETERY OR CREMATORY Parklawn					23d. LOCATION (City, town or county) (State) Montgomery, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber					24a. ADDRESS Laytons ville, Md.					25a. REC'D BY REGISTRAR OCT 9 '61									
										25b. REGISTRAR'S SIGNATURE Arthur S. Huns									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

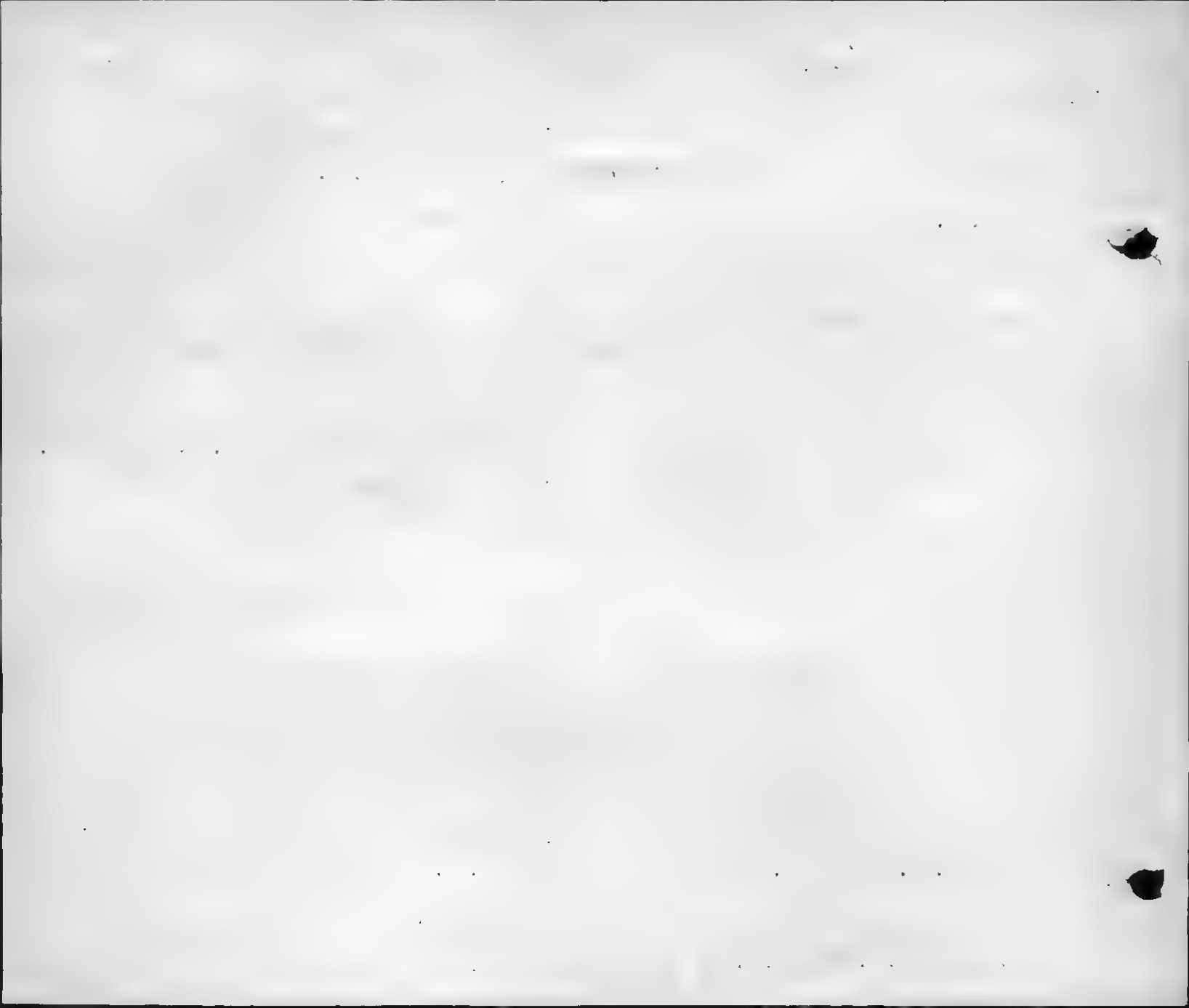
CERTIFICATE OF DEATH

11692

11678

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MARYLAND (Rural)</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. NAVAL HOSPITAL</u> e. NAME OF DECEASED (Type or print) <u>JOHN HENRY TYLER</u> f. SEX <u>MALE</u> g. COLOR OR RACE <u>NEGROID</u> h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> i. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOOD PREPARATION</u> j. KIND OF BUSINESS OR INDUSTRY <u>CIVILIAN EMPLOYEE</u> k. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA</u> l. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> m. FATHER'S NAME <u>NELSON TYLER</u> n. MOTHER'S MAIDEN NAME <u>Cora Lee</u> o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> p. SOCIAL SECURITY NO. <u>579/01/7000</u> q. INFORMANT <u>ELIZABETH ESSIE TYLER (WIFE)</u> Address <u>3604 18th STREET N. E. WASH., D.C.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON, D. C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D. C.</u> d. STREET ADDRESS <u>3604 18th STREET, NORTH EAST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. AGE (In years last birthday) <u>51</u> g. DATE OF DEATH <u>OCTOBER 11 1961</u> h. BIRTHDAY <u>JULY 23, 1910</u> i. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA</u> j. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> k. MOTHER'S MAIDEN NAME <u>Cora Lee</u> l. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> m. SOCIAL SECURITY NO. <u>579/01/7000</u> n. INFORMANT <u>ELIZABETH ESSIE TYLER (WIFE)</u> Address <u>3604 18th STREET N. E. WASH., D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Arteriosclerosis</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>61</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct 11 1961</u> to <u>Oct 11 1961</u> , that (X) (we) last saw the deceased alive on <u>Oct 11 1961</u> , and that death occurred at <u>7:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D. L. Kettering</u> 22c. PHYSICIAN'S NAME (Type) <u>D. L. KETTERING, LT MC USN</u>		22b. DATE SIGNED <u>12 Oct 1961</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>16 Oct 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington D. C.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON AND JENKINS</u> ADDRESS <u>Funeral Home, Washington, D.C.</u>			

TO: SPECIAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

11693
MONTGOMERY
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>16-8-61</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5609-18th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard, Sylvester Underwood</u>		4. DATE OF DEATH Month <u>16</u> Day <u>-2</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>May</u> Day <u>1</u> Year <u>01</u>	9. AGE (In years last birthday) <u>60</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Ra</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard T. Underwood</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. McCormick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Harp Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4-2-61</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u></u> e.m. <u></u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL NAME (Type) <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>10-2-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) <u>Wash DC</u>	(State)	
23. FUNERAL DIRECTOR <u>Thomas B. Humber</u>		ADDRESS <u>3831-6A Ave NW</u>		24a. REC'D BY REGISTRAR <u>OCT 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
 15M 9/60

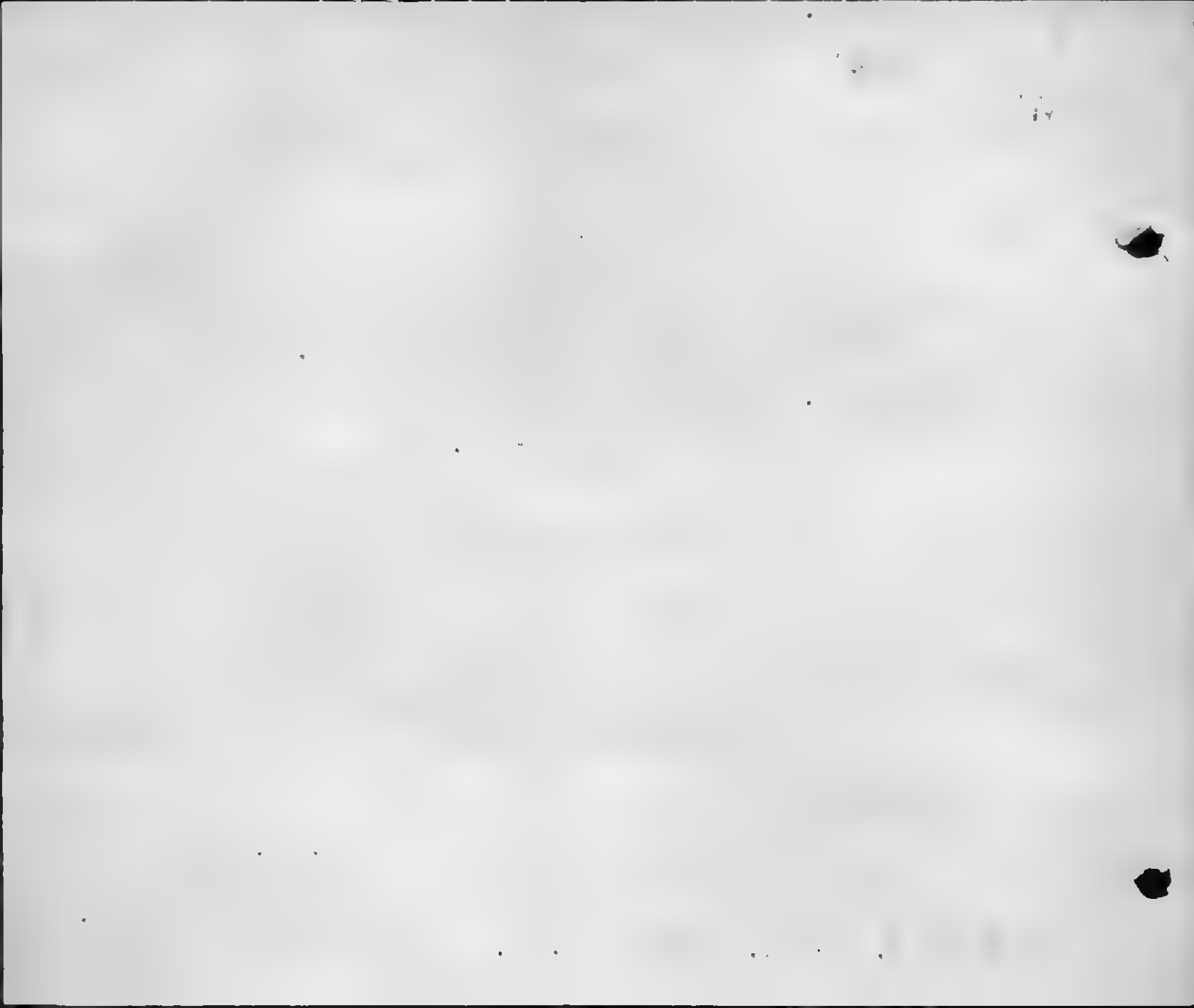
(M)

(I)

137

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11694 CERTIFICATE OF DEATH 11680											
1. PLACE OF DEATH a. COUNTY <u>Montg</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> c. LENGTH OF STAY IN 1b <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>At Home.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> d. STREET ADDRESS <u></u>					
3. NAME OF DECEASED (Type or print) <u>Marjorie Minnie Unglesbee</u>						4. DATE OF DEATH <u>Oct 31 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21-1890</u>		9. AGE (In years last birthday) <u>71 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Adamstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles M. Grimes</u>						14. MOTHER'S MAIDEN NAME <u>May Schaëffer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give war or dates of service) <u></u>						16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Harry W. Unglesbee</u>		Address <u>As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertension</u> DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u></u>											
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 11, 1958</u> to <u>Oct 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 31, 1961</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Vernon E. Martens</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 1 - 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>						22d. ADDRESS <u>Germantown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		23d. LOCATION (City, town or county) <u>Frederick</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg, Md.</u>						25a. REC'D BY REGISTRAR <u>NOV 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11661

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN It

12 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7723 Eastern Ave., Apt. 24

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

7723 Eastern Ave - Apt 24

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Mary Bertha Urban

4. DATE OF DEATH

Oct 3 1961

5. SEX

Female

6. COLOR OF SKIN

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-8-1900

9. AGE (In years last birthday)

61 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Mins.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saleslady

10b. KIND OF BUSINESS OR INDUSTRY

Shoe Store

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Farneski

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

579-14-1663

17. INFORMANT

Victoria Patrode (daughter)

Address

Stem 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Bluschi

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. BLUSCHI

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

10-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/5/61

22c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven Cemetery

22d. LOCATION (City, town, or county)

Montgomery County, Maryland

23. FUNERAL DIRECTOR

Raymond A. Ziska

ADDRESS

8434 Georgia Avenue

Warner E. Pumphrey, Inc. Silver Spring, Maryland

24a. REC'D BY REGISTRAR

OCT 5 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Hance

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

A . . .

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

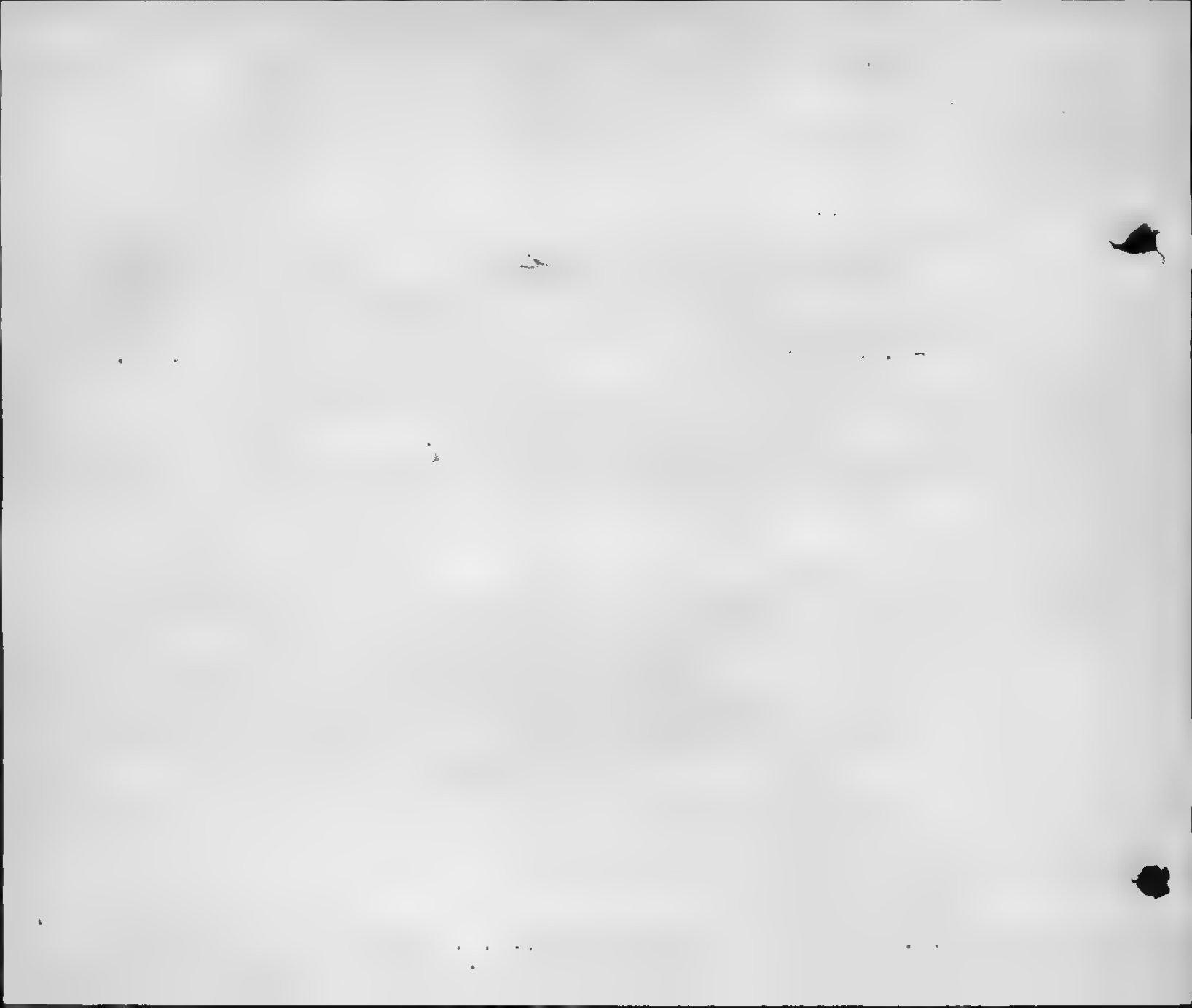
11696

11662

FOR STATE
HEALTH DEPT.

1
M
X
I
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>German town - R-2</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>md R-118</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>54 Chevy chase</u>			
f. STREET ADDRESS <u>4116 Aspen st</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oscar Paul Vogel</u>				4. DATE OF DEATH <u>Oct 12 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-95</u>	
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attny - U.S. Government - Rev.</u>				11. BIRTH-PLACE (State or foreign country) <u>Ind</u>			
13. FATHER'S NAME <u>Charles Vogel</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Fessler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Anne Vogel (wife)</u>				Address <u>Ind R</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Carbon-monoxide poisoning</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hose attached to exhaust extending in auto</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose attached to exhaust extending in auto</u>			
20c. TIME OF INJURY Month, Day, Year <u>10-12-1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>md R-118</u>				20f. City or town <u>md German town montg md</u>			
20g. County <u>md</u>				20h. State <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>10-12-61</u>			
22. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. ADDRESS (Street, city, town, or county) <u>Frank J. Broschart</u>				22. ADDRESS (City, town, or country) (State) <u>10-12-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>10/14/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Prince Georges County, Md.</u>			
23. FUNERAL DIRECTOR <u>The S.H.Hines Company-2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>Washingon 9, D.C.</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE <u>OCT 16 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

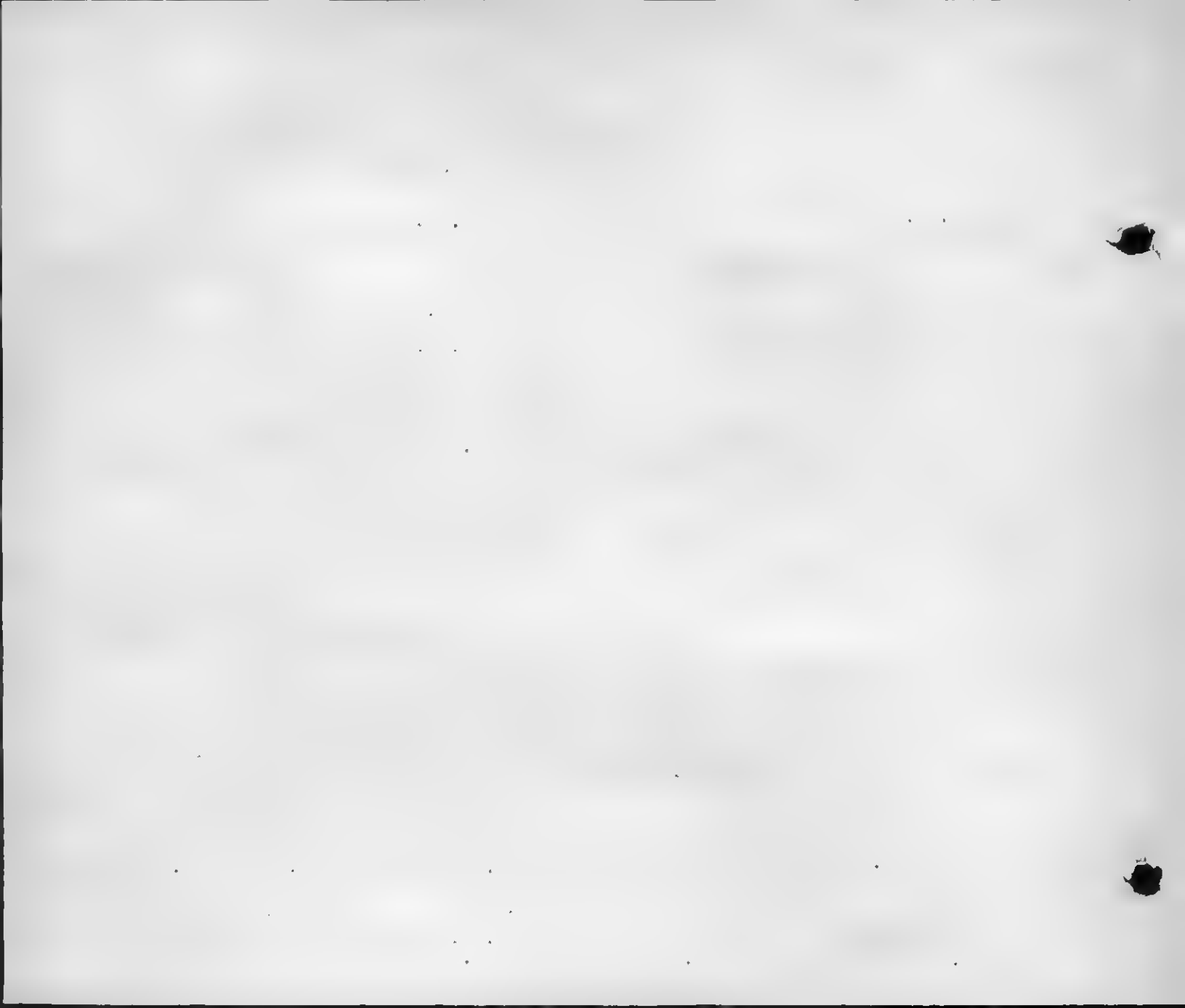
CERTIFICATE OF DEATH

11697

11683

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swannanoa	
c. LENGTH OF STAY IN b. 49 days		d. STREET ADDRESS Rt. 1, Box 261	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick	F. First Volbeda	4. DATE OF DEATH Month October	Day 10
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1907
9. AGE (in years last birthday) 54-2 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer (Chaplain)	11. BIRTHPLACE (County & State, or foreign country) Michigan	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Volbeda	14. MOTHER'S MAIDEN NAME Alice Groendyck	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II & Korea	
16. SOCIAL SECURITY NO. 246-58-1983		17. INFORMANT WIFE: Mrs. Catherine C. Volbedia, Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia 04-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Autoimmune Hemolytic Anemia DUE TO (c) Multiple Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 23, 1961 to October 10, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 10, 1961 , and that death occurred at 2:13 AM from the causes and on the date stated above.			
22a. SIGNATURE John M. Lewis		22b. DATE SIGNED 10 October 1961	
22c. PHYSICIAN'S NAME (Type) JOHN M. LEWIS LCDR MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial-Shipment 10-10-61		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		23d. LOCATION (City, town or county) (State) Swannanoa, North Carolina	
25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Catherine S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

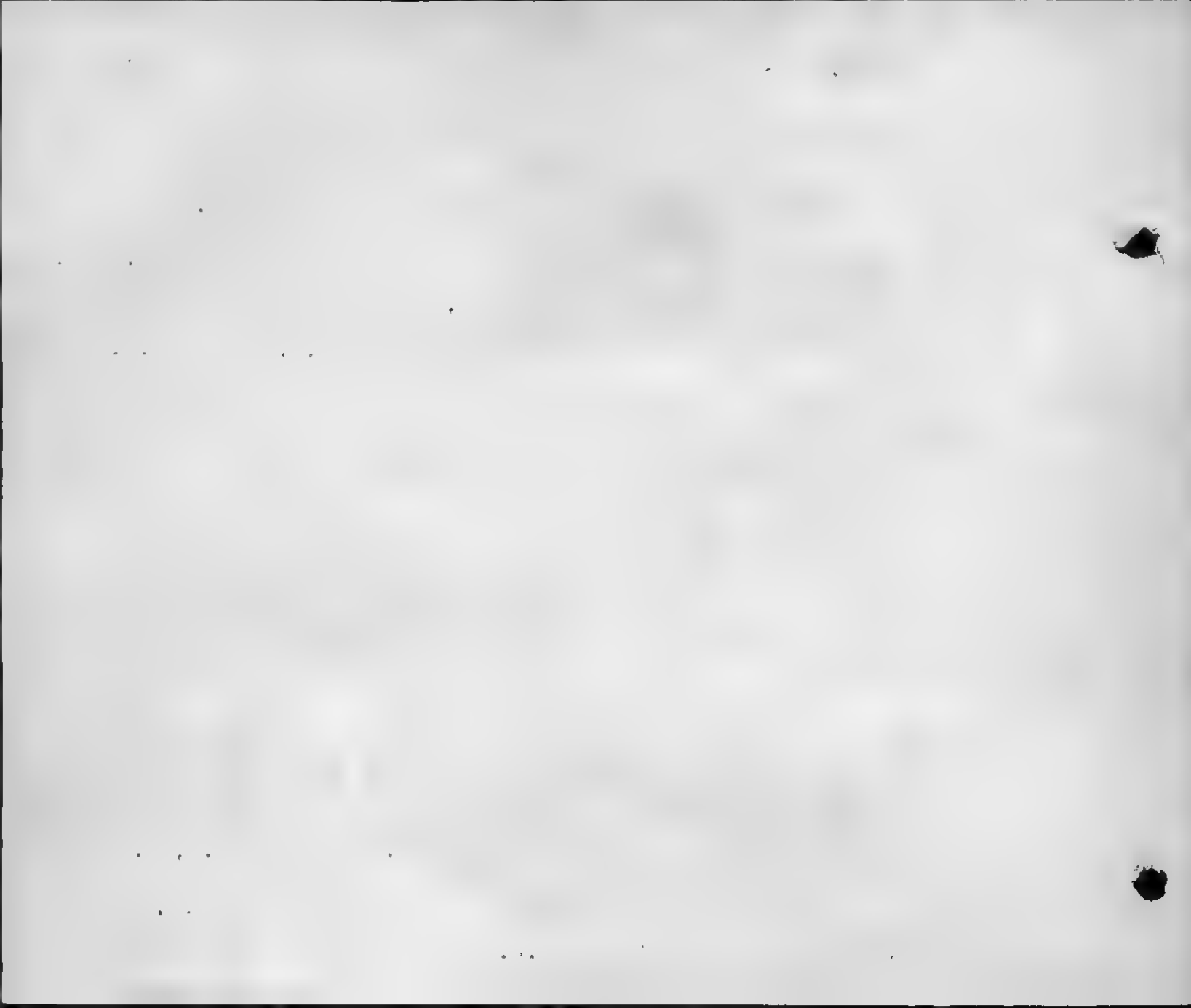


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11698 Item 2 Film 5-20 10-27-61 ink 11684											
1. PLACE OF DEATH											
a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Colesville		c. LENGTH OF STAY in 1b		a. STATE /MD/ Wash. D.C.		b. COUNTY Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Belmont Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Colesville Washington, D.C.		4/X	
3. NAME OF DECEASED (Type or print)		Catherine Kane Wahl				d. STREET ADDRESS		701 3th. St. N.E.		* IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 14, 1869		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		Geier		14. MOTHER'S MAIDEN NAME		unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis											
3-4x DUE TO (b) Gen'ized arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 2/1/1961 to 10/20/1961, that (I) (we) last saw the deceased alive on 10/17/1961, and that death occurred at 12:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Donald Nelson M.D.											
22b. DATE SIGNED 10/22/61											
22c. PHYSICIAN'S NAME (Type) Donald Nelson											
22d. ADDRESS 10620 Ga. Ave Sil Sp., Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 10-21-61											
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet											
23d. LOCATION (City, town or county) (State) Washington D.C.											
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.											
25a. REC'D BY REGISTRAR DATE OCT 23 '61											
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus											

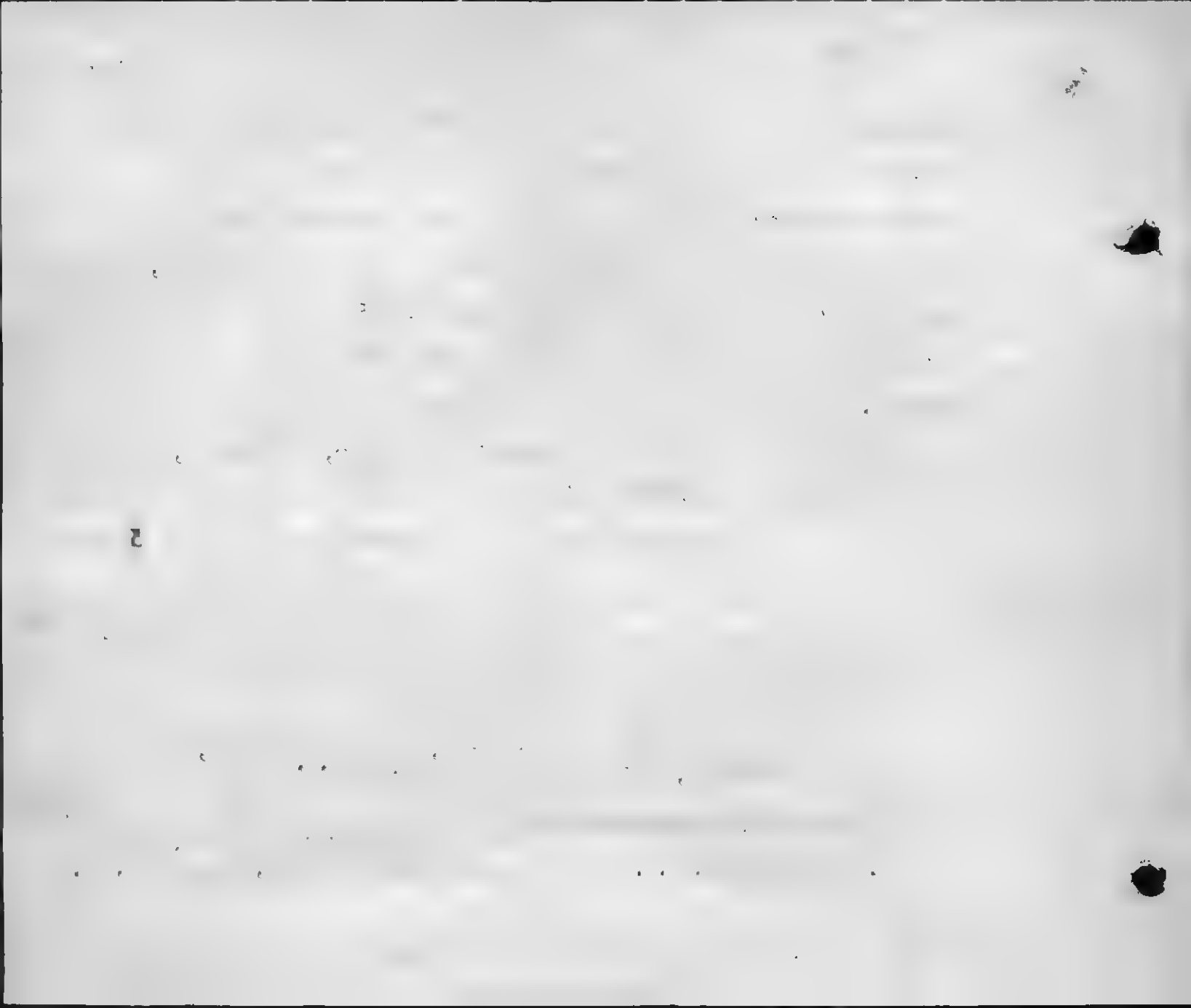


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11699 CERTIFICATE OF DEATH 11685											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 63 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 8515 Greenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LAURA ANN WARE 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH November 24, 1958 9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR: Months 9 , Days 19 , Hours 61				4. DATE OF DEATH October 9, 1961							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 13. FATHER'S NAME Herrell O. Ware				10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (Country & state, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA				14. MOTHER'S MAIDEN NAME Judith Ann Labofish 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT The Medical Record 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 20410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphocytic Leukemia with splenomegaly and hepatomegaly DUE TO (c) 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 7, 1961 to October 9, 1961 , that (I) (we) last saw the deceased alive on October 9, 1961 , and that death occurred at 7:50 p.m. from the causes and on the date stated above.											
22a. SIGNATURE J. David Heywood M.D. 22c. PHYSICIAN'S NAME (Type) J. DAVID HEYWOOD, M.D.				22b. DATE SIGNED 10/10/61 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/13/61		23c. NAME OF CEMETERY OR CREMATORY Ge. Wash. Mem.		23d. LOCATION (City, town or county) (State) At Ge. Wash. Mem. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc				ADDRESS 1400 Chapin St N.W. Wash. D.C.		25a. REC'D BY REGISTRAR 11 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

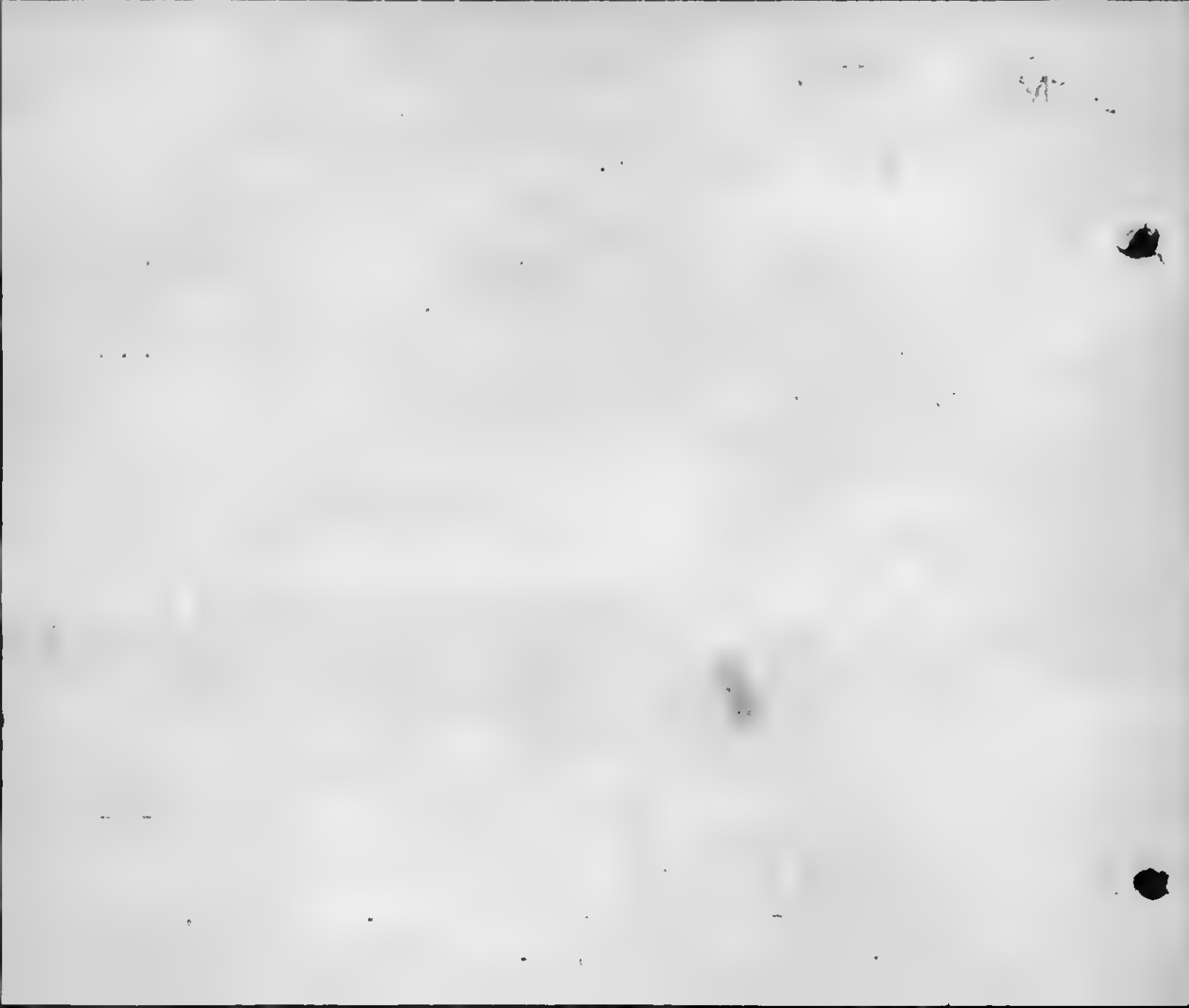
CERTIFICATE OF DEATH

11700

11688

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		d. STREET ADDRESS 9909 Thornwood Rd.	
3. NAME OF DECEASED (Type or print) Walter P Warendorff		4. DATE OF DEATH Month October Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Civil Engineer		9. AGE (In years last birthday) 57 yrs.	
11. BIRTH-PLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Warendorff		14. MOTHER'S MAIDEN NAME Clare Karge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Navy WW II	
17. INFORMANT Helen (wife)		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Esophagus metastatic (generalized) (operated July 1960)			
DUE TO (b) Heart			
DUE TO (c) Stroke			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1958 to 10/31/61 , 19....., that (I) (we) last saw the deceased alive on 10/30/61 19....., and that death occurred 5:15AM from the causes and on the date stated above.			
22a. SIGNATURE Sam Allen		22b. DATE SIGNED 10-31-61	
22c. PHYSICIAN'S NAME (Type) SAMUEL ALLEN		22d. ADDRESS Kensington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE NOV 3 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



1
FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a physician, or by a funeral director, or by a coroner, or by a health officer, or by a member of the State Board of Health, or by its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11687

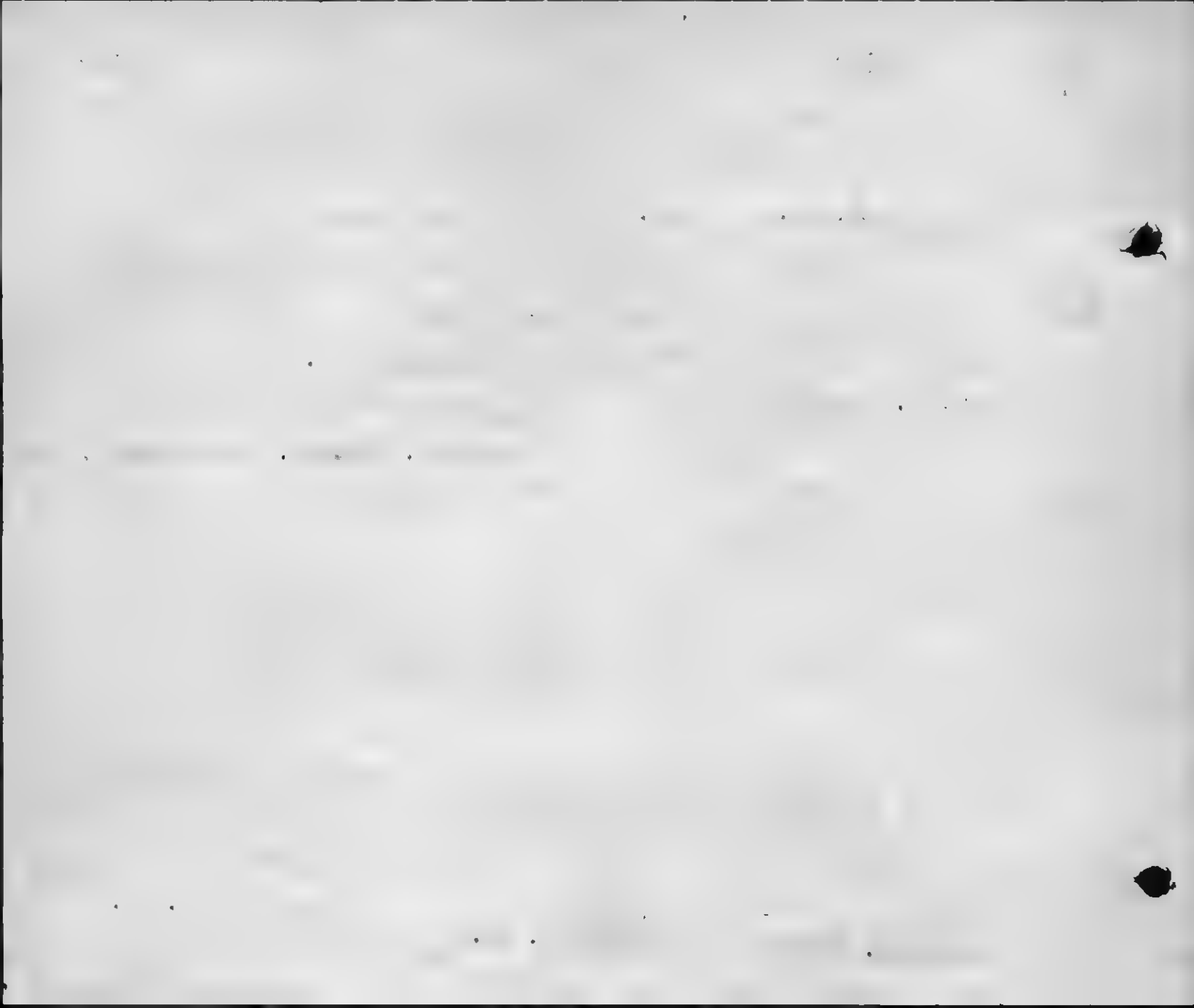
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>168 36th Place, S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel McKinley Warren</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1926</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Samuel McKinley Warren, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Garvett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 1944-46</u>		16. SOCIAL SECURITY NO. <u>1911-46</u>	
17. INFORMANT <u>James A. Warren</u>		18. ADDRESS <u>Seven Locks Road, Cr in John</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral laceration + hemorrhage</u> 782X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>penetrating wound of skull by ax</u> DUE TO (b) <u>penetrating wound of skull by ax</u> DUE TO (c) <u>penetrating wound of skull by ax</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laceration of left arm</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>struck with an ax</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>struck with an ax</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:50 PM 10-29-61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>accused home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>10-29-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		22d. LOCATION (City, town, or country) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>John T. Pharo</u>		ADDRESS <u>3015-12th St NE</u>	
24a. REC'D BY REGISTRAR <u>NOV 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11702 CERTIFICATE OF DEATH 11688									
1. PLACE OF DEATH a. COUNTY <u>Montg</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg. Co. Gen Hosp.D OA</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>2 James Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Belle</u> Last <u>Watkins</u>					4. DATE OF DEATH Month <u>Oct</u> Day <u>12th</u> Year <u>1961</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Oct 25-1898</u>				
9. AGE (In years last birthday) <u>62 yrs.</u>					10. IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>17</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				
13. FATHER'S NAME <u>James B. Hawkins</u>					14. MOTHER'S MAIDEN NAME <u>Annie Belle Burne</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>Clayton K. Watkins. Gaithersburg, Md.</u>				
17. INFORMANT <u>Clayton K. Watkins. Gaithersburg, Md.</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> (b) <u>Pneumonia</u> (c) <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20b. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20e. (City or town)					20f. (County)				
20g. (State)					21. I certify that (I) (this hospital) attended the deceased from <u>10-12-1961</u> to <u>10-12-1961</u> , that (I) (we) last saw the deceased alive on <u>10-12-1961</u> , and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>S.J. Broschert</u> M.D.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>F.J. Broschert</u>					22d. ADDRESS <u>4 Russell Ave. Gaithersburg Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>10-14-61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>					23d. LOCATION (City, town or county) <u>Gaithersburg. Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> Address <u>Gaithersburg. Md.</u>					25a. REC'D BY REGISTRAR <u>Oct 16 61</u> DATE				
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
15M 9/59

11703
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11683

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>2 MOS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4015 Adams Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSANNAH L. WICKHAM</u>				4. DATE OF DEATH Month Day Year <u>10 4 1961</u>			
II. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1886</u>	
9. AGE (In years lost birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wheeling, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Stamm</u>				14. MOTHER'S MAIDEN NAME <u>Hedra O'Malley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Mrs. Charles B. Heineman <u>4015 Adams Drive Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (left side)</u> DUE TO <u>Anteriosclerosis - generalized (ag. 75)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Senility due to above</u> (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>yr</u> <u>yr</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/11</u> , 19 <u>11</u> to <u>10/4/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-2-11</u> , 19 <u>11</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>SAM ALLEN</u> SAM ALLEN, M.D. Kensington, Maryland				22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u> 22d. ADDRESS <u>10,407 Fawcett Street, Kensington Maryland</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Ziska</u> Warner E. Pumphrey, Inc. Silver Spring, Maryland				25a. REC'D BY REGISTRAR DATE <u>OCT 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11704

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL		d. STREET ADDRESS 1819 G STREET NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month OCT Day 8 Year 1961	
5. SEX F	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JAN 1874
9. AGE (In years, months, and days) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BROOKLYN N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEO. L. A. MARTIN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NOIVE	
17. INFORMANT HUSBAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO ESSENTIAL HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 1, 1944 , to OCT 8, 1961 , that (I) (we) last saw the deceased alive on OCT 8, 1961 , and that death occurred at 6:00 PM , from the causes and on the date stated above			
22a. SIGNATURE Joseph S. Anderson M.D.		22b. DATE SIGNED 10/9/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5206 Newbury Dr. Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 10/9/61	
23c. NAME OF CEMETERY OR CREMATORY Washington		23d. LOCATION (City, town, or county) (State) Newark, N.J.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph S. Anderson ADDRESS 1755 Pa Ave NW		25a. REC'D BY REGISTRAR DATE OCT 11 '61	
25b. REGISTRAR'S SIGNATURE William S. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11705 It m 9 11m 647 10/10/61 iwk 11691											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 7 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				e. STREET ADDRESS 1706 Republic Road				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Eugene Wilson				4. DATE OF DEATH 10/7/61				5. AGE (In years) 81 yrs.			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/30/79		9. AGE (In years) 81 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during past year, or last year even if retired) Machinist Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office				11. BIRTHPLACE County & State, or foreign country Virginia			
13. FATHER'S NAME - UNKNOWN				14. MOTHER'S MAIDEN NAME Anna Baggett				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give word or dates of service) Yes				16. SOCIAL SECURITY NO 577-18-2223				17. INFORMANT Eugene Austin Wilson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CARDIAC ARRHYTHMIA (VENTRICULAR) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury on Part I of form) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State) 21. I certify that (I) (This hospital) attended the deceased from 8/29/61 to 10/8/61, that (I) saw the deceased alive on 10/7/61, and that death occurred at 2:05 AM from the causes and on the date stated above. 22a. SIGNATURE John P. Martin M.D. 22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, M.D. 22d. ADDRESS John P. Martin Sandy Spring, Maryland 22e. REC'D BY REGISTRAR OCT 10 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Hines											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/11/61				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
23d. LOCATION (City, town or county) Prince George's County, Md.				23e. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23f. ADDRESS 8434 Georgia Avenue			
23g. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23h. ADDRESS 8434 Georgia Avenue				23i. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

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VR AIS (4)
15M 9/59

11706

11892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Rockbridge</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>700 Hudson Avenue</i>		d. STREET ADDRESS <i>509- Rockwell Ave -</i>	
3. NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>GEORGE</i> Last <i>WILSON</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>24</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 9, 1881</i>
9. AGE (n years last birthday) <i>80</i> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James George</i>		14. MOTHER'S MAIDEN NAME <i>Ida Parr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs. R.F. Steidtmann</i>		Address <i>Providence Hosp APO-55 New York - N.Y.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary artery occlusion</i> DUE TO (c) <i>Coronary arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>10 minutes</i> <i>3:20 a</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>19</i> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1957 to <i>Oct 24</i> 1961, that (I) (we) last saw the deceased alive on <i>Oct 20</i> 1961, and that death occurred at <i>7:30 a</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Samuel T. Kimble</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>S. T. KIMBLE</i>		22d. ADDRESS <i>927 Peachtree Dr., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct 28, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>New Providence Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Lexington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Oct 27 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		DATE	



1

18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11707

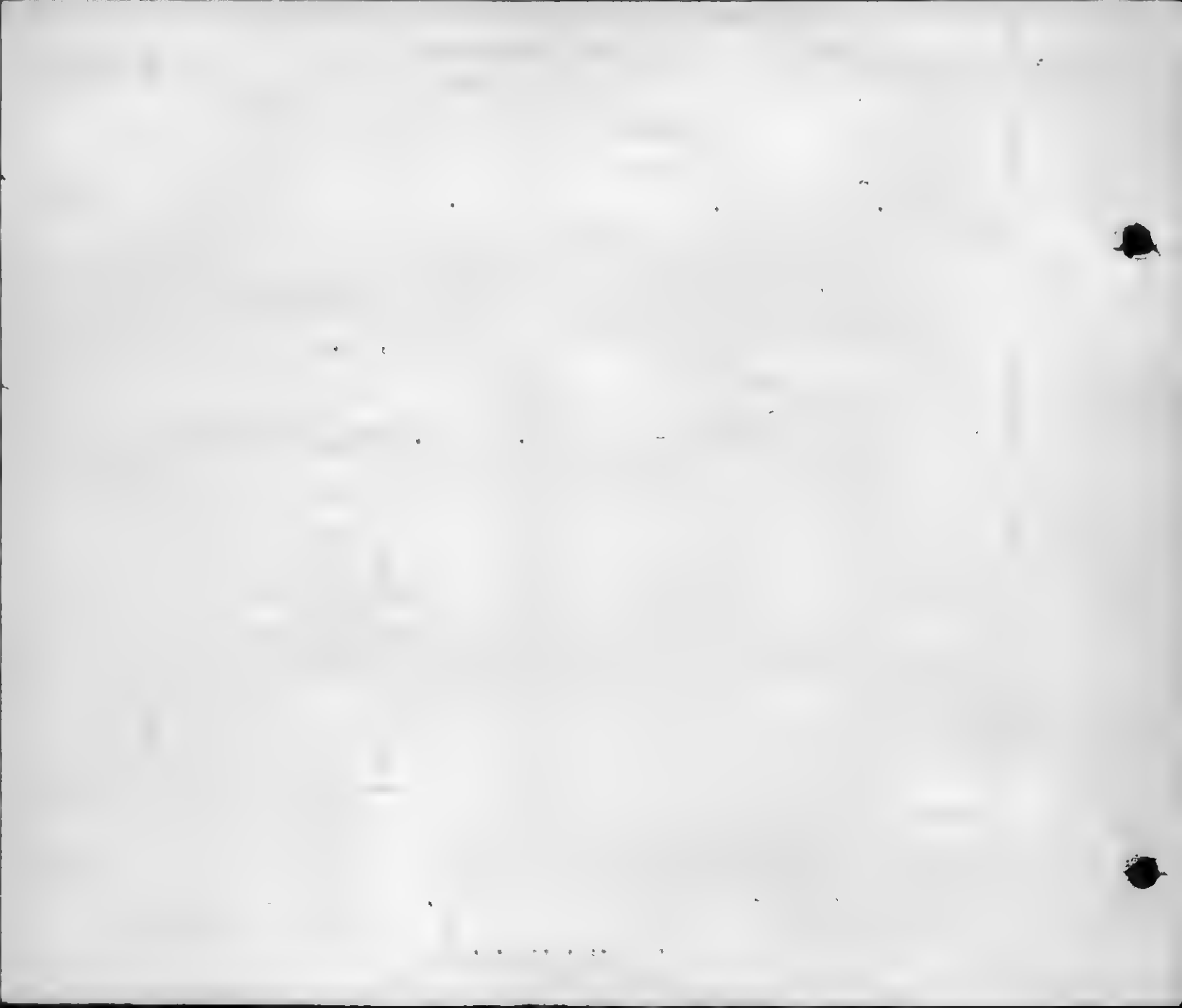
CERTIFICATE OF DEATH

Reg. Dist. No. 1609

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3916 W. UNDERWOOD ST.				d. STREET ADDRESS 3916 W. UNDERWOOD STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Richard Bayly Winder				4. DATE OF DEATH Oct. 6, 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/1892	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY INVESTMENT BANKER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME RICHARD BAYLY WINDER				14. MOTHER'S MAIDEN NAME CATHERINE STREET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WORLD WAR 1 & 2 ---		17. INFORMANT MRS. JULIA P. WINDER, SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 75 hrs 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1959 to Oct 6, 1961 , that I last saw the deceased alive on Oct. 3, 1961 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis T. Sharpe M.D.				ADDRESS (Street, city or town, state) 4105 Wisconsin Ave. Wash. D.C.			
DATE SIGNED Oct 10 1961							
PHYSICIAN'S NAME (Type) Francis T. Sharpe M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/10/61		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Williams, Inc.				ADDRESS 1756 PA. AVE., N.W., D.C.		24a. REC'D BY REGISTRAR Oct 10 1961	
24b. REGISTRAR'S SIGNATURE Constance S. Haines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11708

Items 1, 4 & 21 Filed 10/25/61

11694

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give real address)

The Clinical Center
5721 Grosvenor Lane

3. NAME OF DECEASED (Type or print)

5. SEX

Female

6. COLOR OR RACE

White

HAZEL

(NONE)

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

WINE

8. DATE OF BIRTH

November 10, 1913

9. AGE (In years, test birthday)

47 yrs.

10. DATE OF DEATH

October 19, 1961

11. AGE (In years, test birthday) Months Days Hours Min.

19 61

12. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Secretary

Government

West Virginia

USA

13. FATHER'S NAME

David M. Albright

Daisy Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

The Medical Record

Not available The Clinical Center, Bethesda 14, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Subarachnoid hemorrhage (Bilateral) Pulmonary Edema

330X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Multiple myeloma, Duodenal ulcer

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

January 30, 1961

21. I certify that (X) (this hospital) attended the deceased from February 2, 1961 to October 20, 1961 that (I) (we) last saw the deceased alive on October 17, 1961, and that death occurred at 10:00 AM on the causes and on the date stated above.

22a. SIGNATURE

John C. Marsh

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

10-20-61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

John C. Marsh

M.D.

The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Oct. 24, 61

23c. NAME OF CEMETERY OR CREMATORY

Shinnston Masonic

23d. LOCATION (City, town or county)

Clarksburg, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

Robert J. Murphy

ADDRESS

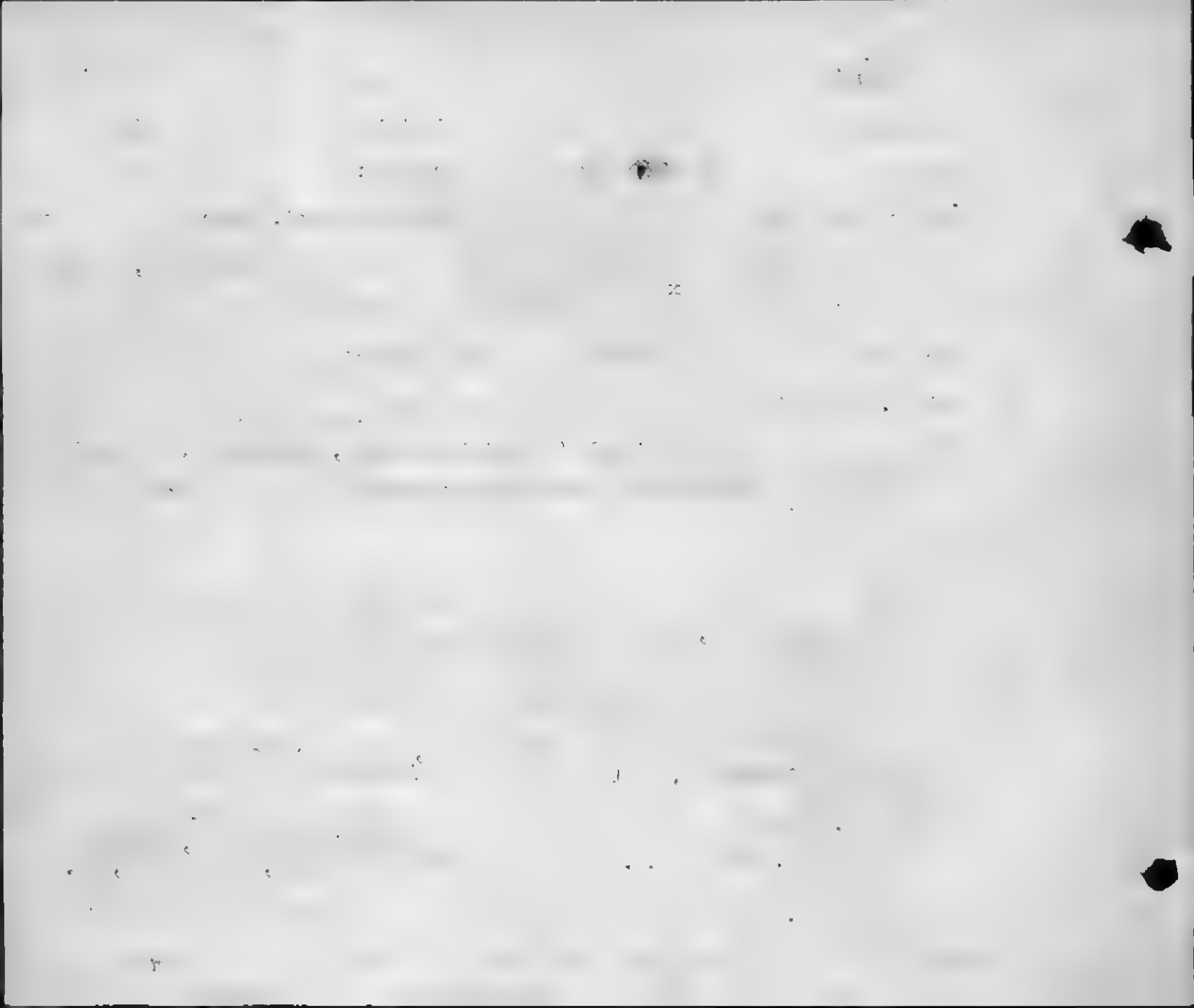
25a. REC'D BY REGISTRAR

DATE OCT 23 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. House

VR A15 (4)
15M 9/60



14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

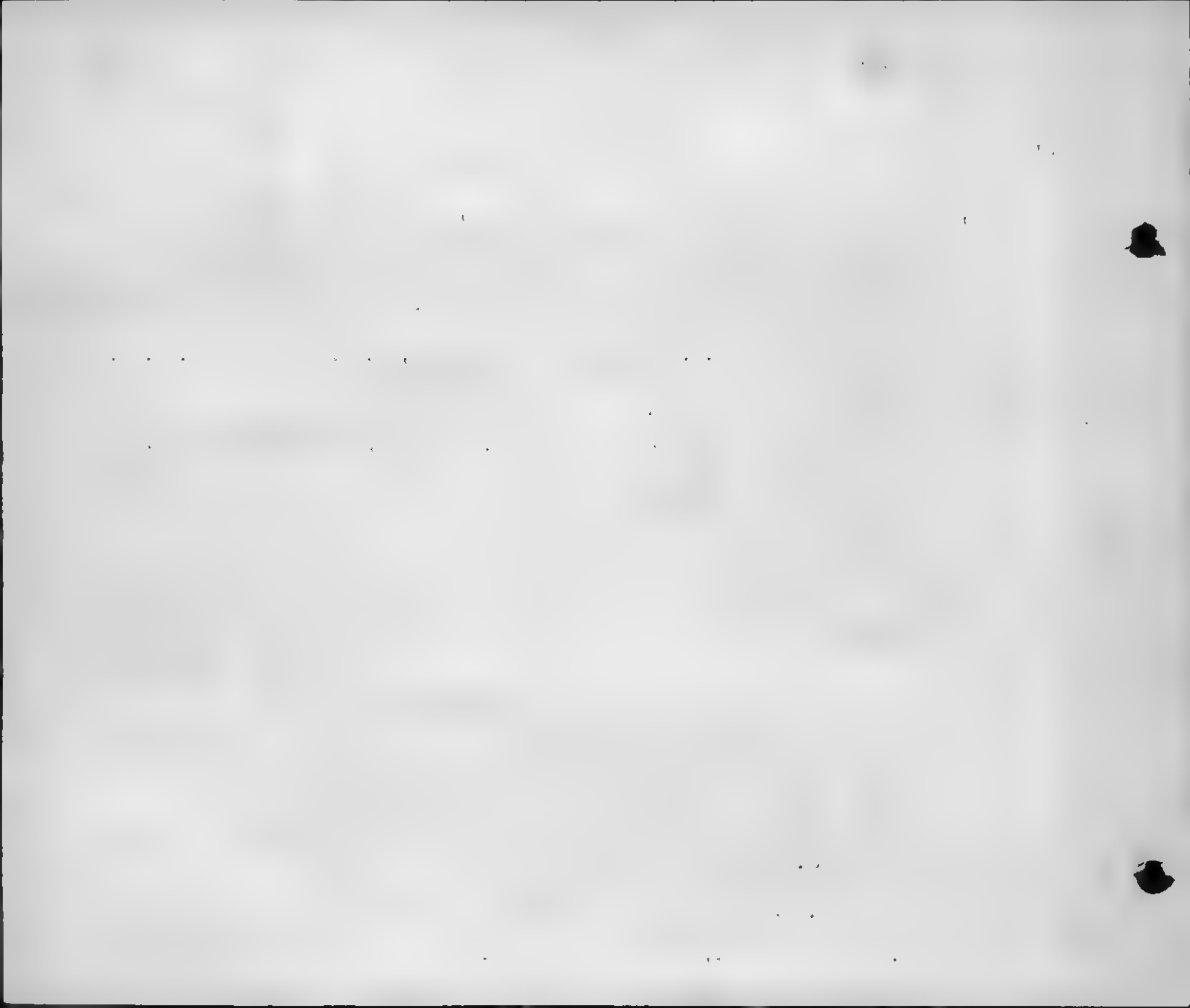
VS. A15ME
5M 7/59

11709
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11695

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY in lb 4 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,015 GRAYSON AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,015 GRAYSON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) FRANK First MICHAEL Middle WISIECKI Last		4. DATE OF DEATH OCTOBER 28 Month 1961 Day 1961 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH FEBRUARY 23, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING AID		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) NEW YORK, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME BLASE WISIECKI		14. MOTHER'S MAIDEN NAME FRANCES CAWALNA		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW #2	
16. SOCIAL SECURITY NO. 096-10-9377		17. INFORMANT OLGA J. WISIECKA		Address 10,015 GRAYSON AVE., SILVER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I History of previous heart disease		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/28/61	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 31, 1961		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, ARLINGTON COUNTY, VA.	
22d. LOCATION (City, town, or country) (State)		22e. REC'D BY REGISTRAR OCT 31 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hanes	
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., Silver Spring, MD.					

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11710

CERTIFICATE OF DEATH

11696

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 14,101 Georgia Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14,101 Georgia Avenue				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Almond Woodworth Sr.				4. DATE OF DEATH October 13 19 61			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1887	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired			10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. Woodworth				14. MOTHER'S MAIDEN NAME Susie Waugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-26-7071			
17. INFORMANT Mrs. Kate M. Woodworth				Address 14,101 Georgia Avenue Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Heart failure DUE TO (c) Cardiomegaly due to aortic stenosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1959 to Oct 13 1961 , that (I) (we) last saw the deceased alive on Oct 11 1961 , and that death occurred at 7:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Richard P. Delaney				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY				22d. ADDRESS 4323 Harvard St, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Montgomery County Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc.				25. REC'D BY REGISTRAR OCT 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0121

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 29-3/4 hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 12808 Meadowood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alice Strode		4. DATE OF DEATH Month 10- Day 23 Year 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-91		9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 10- Days 23		11. IF UNDER 24 HRS. Hours 19 Min. 61					
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Montgomery		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Strode		14. MOTHER'S MAIDEN NAME Louise Hendey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Broncho pneumonia with abscess (lobular) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bacteria left ankle		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Fell on floor at home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor at home		20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-22 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Silver Spring Montg Md		20g. (County) Montgomery		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-24-61		ACTUAL SIGNATURE Frank J. Broschatt		EXAMINER'S NAME (Type) FRANK J. Broschatt		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/61		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or country) Washington D.C.	
23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS 434 Georgia Avenue Silver Spring, Maryland		24a. REC'D BY REGISTRAR OCT 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines															

MEDICAL CERTIFICATION

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11711

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